Expanded Impact Child Survival Program, Final Evaluation Report
Sofala Province, Mozambique

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Acronyms and Abbreviations

AIDS	Acquired immunodeficiency syndrome
BLSC	Bellagio Lives Saved Calculator
CCS	Centro Cooperazione Sviluppo de Italy
CDD	Control of diarrheal diseases
CG	Care Group
C-HIS	Community-based health information system
CHW	Community health worker
C-IMCI	Community-based integrated management of childhood illness (one Leader Mother in each Care Group was trained in C-IMCI and is referred to as a C-IMCI LM)
CSHGP	Child Survival and Health Grants Program
CSP	Child survival project
CTO	Chief Technical Officer
CUAMM	Collegio Universitario Aspiranti Medici Missionari (in Italian – also called Doctors with Africa in English)
DALY	Disability-adjusted life year
DIP	Detailed implementation plan
DHS	Demographic and health survey
EOP	End of project
EPI	Expanded Programme on Immunizations
FGD	Focus group discussion
FH	Food for the Hungry
FH/M	Food for the Hungry/Mozambique
HH	Households
HIS	Health information system
HIV	Human immunodeficiency virus
HPSOS	*Oficials de Saude* (District Supervisors for the FH CSP)
HQ	Headquarters
IMCI	Integrated management of childhood illness.
ITN	Insecticide-treated mosquito bednet
KPC	Knowledge, practice and coverage survey
LiST	Lives Saved Tool
LM	Leader Mother (C-IMCI Leader Mothers were trained in community-based IMCI, one for every twelve mothers and 12-14 LMs per Care Group)
LOE	Level of effort
LQAS	Lot quality assurance sampling
m	Month
MDG	Millennium Development Goal
M&E	Monitoring and evaluation
MUAC	Mid-upper arm circumference (a rapid nutrition screening technique)

MOH	Ministry of Health
MOU	Memorandum of understanding
MPH	Masters in Public Health
MTE	Mid-term evaluation
NCHS	National Center for Health Services
NGO	Non-governmental organization
OR	Operations research
ORS	Oral rehydration salts
ORT	Oral rehydration therapy
POU	Point of use
PSI	Population Services International (an international NGO specializing in social marketing)
Q	Quarter
QIVC	Quality improvement and verification checklist
RapidCATCH	Core Assessment Tool on Child Health
RHFs	Recommended home fluids (for diarrhea)
TOT	Training of trainers
U2MR	Under-two-year mortality rate
U5MR	Under-five-year mortality rate
US	United States
USAID	United States Agency for International Development
VAD	Vitamin A deficiency
WAZ	Weight-for-age *Z* score
WHO	World Health Organization
y	Year

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Executive Summary

Project Description, Goals and Objectives

Food for the Hungry's expanded impact child survival project builds on the success of its Title II Food Security Programs in Sofala Province from 1995 to 2004 and extends the Care Group methodology it developed there to communities having a total population of 1.1 million people and 219,617 beneficiaries (148,444 children 0-59 months of age, 71,173 WRA, including 23,767 pregnant women) in seven districts. The Care Group methodology uses a paid Promoter to teach a group of 10-12 Leader Mothers a new health promotion message every two weeks, and this Leader Mother teaches 10-12 neighbors in surrounding households. The health promotion messages focused on nutrition (including immediate and exclusive breastfeeding for the first six months of life, complimentary feeding, micronutrients, and rehabilitation of malnourished children with local foods); water treatment, sanitation and hygiene; dangers signs during pregnancy and among children for which health care should be sought; disease prevention (e.g., ITNs for malaria); the need for routine preventive health services (immunizations and prenatal care); and the importance of giving birth at the nearest health center. Project staff began implementing activities in March 2006 in Area A (Caia, Chemba, Marringue, and Manga districts of Sofala Province), with 42% of the project's 219,617 beneficiaries of 0-23m-old children, their mothers and pregnant women. In February 2009 the project expanded to Area B (Dondo, Gorongosa, and Nhamatanda districts), with the remaining 58% of project beneficiaries.

The project had the following goals and objectives:

- Significantly reduce morbidity and mortality – especially among children 0-23 months of age and pregnant women;
- Increase access to community and household health providers in the program areas who are trained in Integrated Management of Childhood Illness (IMCI);
- Transfer the knowledge, skills, tools, and passion needed for effective and sustainable community health development through the Care Group model to project partners – including Leader Mothers – in order to continue child survival activities once the project has ended.

The project had two main interventions/program components: nutrition (70% of project effort) and control of diarrhea diseases (CDD) (30% of project effort). Within the nutrition component were the following interventions:

- IMCI integration/training of community health workers (CHWs)
- Promotion of exclusive breastfeeding for the first six months of life and then continued (with appropriate complementary feeding) until 24 months of age
- Promotion of appropriate complementary feeding beginning at six months of age
- A modified Hearth program to rehabilitate malnourished children
- Growth monitoring (mid-upper arm circumference – MUAC – measurements in the community and promotion of growth monitoring at the health centers)
- Promotion of maternal nutrition

Within the CDD component were the following interventions:

- IMCI integration/CHW training
- Promotion of handwashing with soap/ash

- Promotion of the use of oral rehydration solution (ORS) and recommended home fluids (RHFs) for episodes of diarrhea
- Promotion of feeding/breastfeeding during and after episodes of diarrhea
- Promotion of care seeking when danger signs develop with diarrhea
- Appropriate case management/counseling
- Point-of-use (POU) water treatment (*Certeza*, a dilute chorine solution)

Several additional interventions/activities were added on mid-project. For example, Leader Mothers were trained to conduct home visits to mothers of newborns (daily during the first week of life, three times during the second week, twice in the third week, and once in the fourth week), at which time infants were checked for danger signs and mothers were counseled/referred.

Key Findings/Result

All 16 project targets established at the outset except for two were met or nearly met (within four percentage points of the target) in both Areas A and B. Most of the targets were met after only two years of project activity in Area A (and the levels were maintained until the time of the final evaluation). The achievements in Area B – which were quite similar to Area A – were attained after only 16 months of implementation. Eighty-eight percent of the increases in coverage in both Areas A and B were statistically significant, and many showed dramatic improvement. For instance, in Area A the percentage of infants less than six months of age being exclusively breastfed increased from 17% to 77% and the percentage of mothers who know at least three danger signs for which they should take their child to a health facility increased from 29% to 87% A. Many other indicators that were not associated with targeted objectives showed major and statistically-significant increases. Both areas demonstrated reductions in levels of malnutrition, and in Area B this reduction was statistically significant. See Table 1 for further details. Furthermore, almost all of the RapidCATCH indicators (a term used to describe a uniform set of indicators for reporting to the US Congress as a Core Assessment Tool on Child Health) that were not project targets showed statistically-significant improvements (9/11 in Area A and 8/11 in Area B). The most dramatic of these was insecticide-treated bednet (ITN) use, which increased by 45 percentage points in Area A and 71 percentage points in Area B, and birth attendance by skilled health personnel, which increased by 27 percentage points in Area A and 19 percentage points in Area B.

Using the current version of the Lives Saved Tool (LiST) calculator (estimating indirectly the number of lives saved based on changes in population coverage of proven child survival interventions), the project saved an estimated 6,848 lives of children less than five years of age. This estimate is calculated assuming a static under-five mortality rate in the absence of the project. We estimate that without the project, based on current trends in Mozambique, there would have been a reduction of one-third of this number of lives saved compared to what would have occurred if mortality rates remained static. Thus, the net difference is 4,590 lives saved that can be attributed to project activities. **Using the uncorrected estimate of 6,848 lives saved, the cost per life saved, the cost per disability-adjusted life year (DALY) averted, and the annual cost per beneficiary are $441, $14.72 and $2.78, respectively.** (If correcting for the changes that could be expected to have occurred without the project [given past trends], the figures are $664, $22, and $2.78 respectively.)

Main Conclusions and Recommendations

As far as we know, this is among the most cost-effective child survival projects ever implemented at scale. The project's achievements further substantiate the value of the Care Group strategy, whose superior effectiveness relative to other strategies is now being demonstrated by an increasing number of projects.

The methods used in this project deserve careful review by policymakers in Mozambique as well as in other countries in Africa and beyond and also by donors and development organizations. An independent assessment of the findings of this evaluation, including a retrospective assessment of under-five mortality changes over the past 15 years, is indicated. Further financial support is needed to maintain and expand this project, to include community-based HIV/AIDS and tuberculosis control activities, and to further disseminate the achievements that have been documented here.

Table 1. Summary of Major Project Achievements

Project objective: Improve child nutritional status			
Project inputs	**Activities**	**Outputs**	**Outcome**
Development of high-quality, practical educational messages and teaching guides Training of Supervisors and Promoters in health promotion messages	Well-crafted educational messages provided by peers to pregnant mothers and mothers of young children Promotion of immediate breastfeeding after birth and exclusive breastfeeding for 6m, and promotion of frequent complementary feeding with local nutritious foods Demonstration of how to use locally available nutritious food for children 6m of age and older	Rates of exclusive breastfeeding increased from 17% to 77% in Area A and from 62% to 87% in Area B Percentage of children 9-23m of age who ate 3+ meals per day increased from 33% to 75% in Area A and from 46% to 66% in Area B The percentage of children 6-23m with oil added to their weaning foods increased from 35% to 86% in Area A and from 57% to 91% in Area B An average increase of 10 percentage points in Group A and 8 in Group B in the percentage of children 6-23m of age consuming specific types of nutritious foods. In Area A, 59% of the food groups showed statistically significant improvements, and in Area B, 38%.	Percentage of children in Area B with moderate or severe undernutrition (weight-for-age) declined by 22% in Area A and 34% ($p<0.05$) in Area B Direct measurement of numbers of childhood deaths reported by Leader Mothers declined in both Areas A and B Estimated U5MR declined by 32% in Area A and 26% in Area B (using LIST).
Project objective: Prevention and appropriate case management of diarrhea			
Project inputs	**Activities**	**Outputs**	**Outcome**
Development of high-quality, practical health promotion messages and teaching guides Training of Supervisors and Promoters in educational messages	Well-crafted educational messages provided by peers to pregnant mothers and mothers of young children	Percentage of mothers who report that they wash their hands with soap or ash before preparing food, before eating, before feeding a child, and after defecating increased from 1% to 51% in Area A and from 13% to 43% in Area B Rates of exclusive breastfeeding increased from 17% to 77% in Area A and from 62% to 87% in Area B Percentage of mothers who can correctly prepare ORS increased from 44% to 85% in Area A and from and from 45% to 84% in Area B Percentage of children age 0-23m with diarrhea in the previous 2 wks who received ORS or RHFs increased from 71% to 93% in Area A and from 63% to 89% in Area B The percentage of children age 0-23m who received increased fluids and increased feeding during an illness in the previous 2 wks increased from 8% to 56% in Area A and from 7% to 55% in Area B Percentage of mothers who know at least three signs of childhood illness that indicate the need for treatment increased from 29% to 87% in Area A and from 60% to 84% in Area B	Levels of utilization of health facilities for acute illness increased (according to anecdotal reports, and consistent with data confirming increased facility utilization for prenatal care and childbirth) Many anecdotal reports of fewer episodes of childhood diarrhea Levels of improved nutrition can be attributed partly to a presumed decrease in the incidence and severity of episodes of diarrhea Direct measurement of numbers of childhood deaths reported by Leader Mothers declined in both Areas A and B

Overview of the Project

Project Goals and Objectives

The project had the following goals:

- Significantly reduce morbidity and mortality – especially among children 0-23 months of age and pregnant women
- Increase access to community and household IMCI-trained health providers in the program areas
- Transfer the knowledge, skills, tools, and passion needed for effective and sustainable community health development through the Care Group model to project partners – including Leader Mothers – in order to continue child survival activities once this project has ended

The project's overall objectives were as follows:

- Improve child nutritional status
- Assure appropriate diarrhea case management
- Increase proportion of mothers of young children who have access to an IMCI-trained provider within one hour of their home
- Assure the sustainability, quality and expansion of the Care Group Model in Mozambique

Specific objectives were as follows:

To decrease malnutrition (underweight) in children 0-23m
To increase exclusive breastfeeding of children 0-5m
To increase feeding frequency of children 9-23m who are fed solid or semi-solids food at least three times a day
To increase the proportion of young children fed nutrient-dense foods
To decrease vitamin A deficiency (VAD) by increasing the proportion of young children who regularly consume vitamin-A rich foods
To decrease VAD by increasing the proportion of young children who are regularly receiving vitamin A supplements
To decrease helminthiasis and improve nutritional status by increasing the percentage of young children who are regularly de-wormed
To increase the proportion of children 0-23m of age who participate regularly in growth monitoring/promotion activities
To increase the proportion of young children with diarrhea who are given oral rehydration therapy (ORT) in order to decrease dehydration and death
To increase feeding of young children during diarrhea
To increase the proportion of mothers of young children who are competent in preparation of oral rehydration solution (ORS)
To increase the proportion of mothers of young children who know when to seek care for sick children
Continue to expand usage and improve the Care Group model in Mozambique

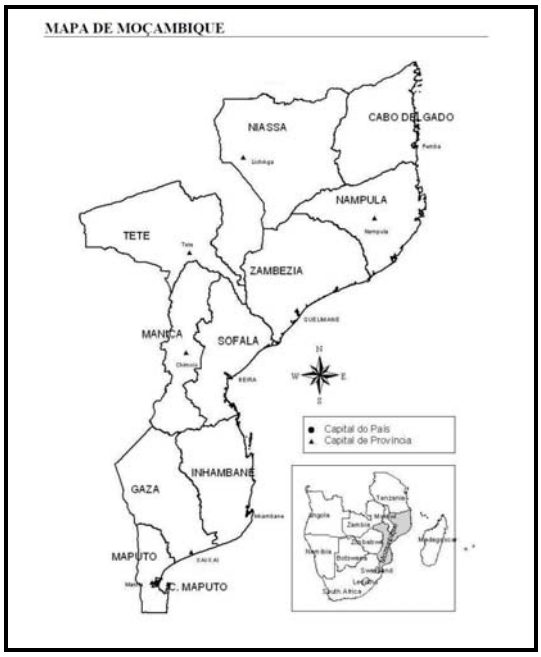
To increase to 80% the proportion of Leader Mothers (LMs) trained in IMCI who can properly use the IMCI protocols for children 1-59m of age

To increase to 80% the proportion of Leader Mothers who are able to do high-quality health promotion

Increase the capacity of local partners and 90% of project communities to effectively address local health needs.

Project Location

Figures 1 and 2 show the location of the project, in seven of the 13 districts of Sofala Province. In 2004, the Province had 1.6 million people, with a density of 23 inhabitants/km^2, which has about the same population density as the entire country.[1] The project area is a relatively sparsely populated rural area of mostly subsistence agriculture. The main crops are cassava, millet, corn, sweet potatoes, beans, and peanuts. Papayas and mangoes are available, as are nutritious nuts from the boabab tree. Villages are reachable by unpaved roads during most of the year, but during the rainy season this is not always possible. There are very few vehicles traveling in the area, and motorcycles and even bicycles are quite scarce, as well. Travel from the project's main office in the town of Beira to the furthest parts of the project in Caia takes nine hours.



[1]Instituto Nacional de Estatística (Moçambique), Ministério da Saúde (Moçambique), MEASURE DHS+/ORC Macro. MOÇAMBIQUE: Inquérito Demográfico e de Saúde 2003. Maputo, Moçambique: Instituto Nacional de Estatística and Ministério da Saúde; 2005.

Figure 1. Map of Southern Africa, Mozambique and Sofala Province[2]

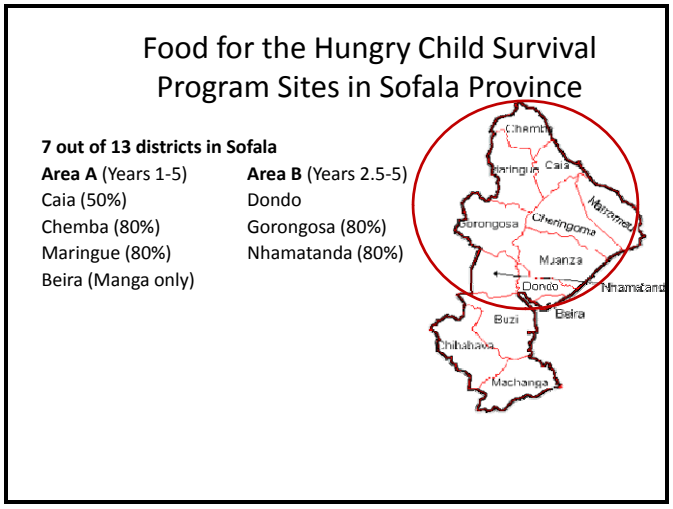


Figure 2. Map of the Project Area in Sofala Province

The level of illiteracy is high. According to the 2003 Demographic and Health Survey (DHS), only half (51%) of girls and women six years of age and older had ever attended school, and only 5% had completed primary or secondary school.[3] Traditional beliefs, especially those related to witchcraft and illness, are still common and quite strong. Traditional healers are abundant.

There are no modern medical services in the project area outside of those provided by the Ministry of Health (MOH). Each of the districts has a health center and a surrounding set of smaller health facilities (health posts). The number of health facilities per district varies from 5-17, and the number of health personnel in each district varies from 33 to 112 personnel. There is only one functioning hospital with surgical capability in the project area. This is in the Nhamatanda district, and it has 128 beds. The hospital has one physician, and surgery is performed by surgical technicians who are non-physicians with formal training.

Project Population

The project reached 219,617 beneficiaries, including 148,444 children 0-59 months of age, 71,173 WRA including 23,767 pregnant women (Table 2). Included in this were 59,258 children 0-23 months of age. The total population served by the project was 1.2 million people. This represents an 11% increase over the number of beneficiaries that the project set out to serve at the outset.

[2] Instituto Nacional de Estatística (Moçambique), Ministério da Saúde (Moçambique), MEASURE DHS+/ORC Macro. MOÇAMBIQUE: Inquérito Demográfico e de Saúde 2003. Maputo, Moçambique: Instituto Nacional de Estatística and Ministério da Saúde; 2005.
[3] Ibid.

Table 2. Project Population Data

Population Category	Target established at the time of writing of the Detailed Implementation Plan (2005)	Estimated beneficiary population reached by the end of the project (2010)
Total population	1,076,055	1,190,764
Estimated number of women of reproductive age	64,448	71,173
Number of children <5 years of age	134,146	148,144
Number of children 0-23 months of age	53,658	59,258
Number of pregnant women	21,521	23,767
Total number of beneficiaries	198,594	219,617

Technical and Cross-cutting Interventions

Table 3 lists the three intervention areas along with the corresponding level of effort (LOE) and end-of-project (EOP) objectives for each.

Table 3. Interventions, Level of Effort (LOE) and End-of-Project Objectives

Intervention	LOE	End-of- Project Objectives
Nutrition	70%	% of underweight children will decline from 27% at baseline to 18% at endline
		% of infants 0-5m who were breastfed in the previous 24 hours will increase from 17% at baseline to 60%
		% of children 6-23m with oil added to their weaning food will increase from 35% at baseline to 80%
		% of children 12-23m who received one vitamin A capsule in the past 6m will increase from 82% at baseline to 95%
		% of children 12-23m who received de-worming medication in the previous 6 months will increase from 24% at baseline to 75%
Control of diarrheal diseases	30%	% of children 0-23m with diarrhea in the last 2 weeks who received ORS and/or recommended home fluids will increase from 71% at baseline to 90%
		% of children 0-23m with diarrhea in the last 2 weeks who were offered the same amount or more food during the illness will increase from 31% at baseline to 60%
		% of mothers of children 0–23m who know at least 3 signs of childhood illness that indicate the need for treatment will increase from 29% at baseline to 75%
Improvement of maternal health	0%	% of mothers able to report at least 2 known maternal danger signs during the postpartum period will reach 80% (this was not measured at the time of the baseline survey)

From July until December 2009, the project provided Mother Leaders and health centers with zinc tablets for treatment of children with diarrhea in two districts (Caia and Manga) as part of a separately funded operations research project funded by the United States Agency for International Development (USAID Leader Mothers and health center staff were taught to administer a 14-day supply of tablets, one per day, for children who developed diarrhea (10 mg/d for children <6m and 20mg/d for children 6m and older). The project is preparing a separate report to USAID about this.

The major cross-cutting strategy was the Care Group methodology, as described further below. The methodology is gaining increasing interest, and its effectiveness in reducing under-five mortality in other settings has been reported elsewhere.[4]

A second major cross-cutting strategy is applied research, consisting of formative and operations research. These include carrying out an Barrier Analysis on key child survival behaviors, an assessment of the local determinants of malnutrition, health facility assessments, and a special study in May 2010 of Care Group functioning. Reports of these key activities are contained in Appendices 17 and 18.

A third major cross-cutting strategy was a strong monitoring and evaluation program that included abbreviated knowledge, practice and coverage surveys (referred to as mini-KPCs), registration of vital events, and verbal autopsies. The mini-KPCs were household interviews of a randomly selected group of 95 beneficiary mothers (19 per district using LQAS) conducted by the Promoters in areas outside of their supervision once or twice a year (usually after the project had finished one or two educational modules). Vital events (births and under-two deaths) were reported by Leader Mothers at each Care Group meeting. Promoters conducted a verbal autopsy using a structured questionnaire for a small number (55) of these, and the project leadership assigned a cause of death based on the findings. Summaries of the vital events and verbal autopsy activities are contained in Appendix 14. The information provided was a great help in guiding the project's activities and reassuring the project leadership that the project was on the right track.

A fourth major cross-cutting strategy was advocacy with the MOH at the provincial and national levels. The project leaders were very active in promoting the project's progress with MOH officials throughout the life of the project.

Project Design

The overall project strategy was to reach every pregnant woman and mother of children 0-23 months of age with targeted educational messages that will lead to health-promoting behaviors and to improved care-seeking behavior. These behaviors would then lead to measurable improvements in the coverage of key child survival indicators and to reductions in the 0-23 month mortality. This was to be accomplished through the Care Group strategy. Additional activities included provision of vitamin A and de-worming medicine to children 12-59 months of age every six months. During the first 2½ years the project worked in four districts (Caia, Chemba, Maringue, and Manga), with about half the project population and with 30 Promoters (Area A). After 2½ years, the project hired 35 additional Promoters and expanded to Area B, which has three other districts (Dondo, Gorongosa, and Nhamatanda). The project continued to work with the same staff in Area A.

Care Group Strategy

The Care Group model (Figure 3) was originally developed 15 years ago in Mozambique by Dr. Pieter Ernst, working with World Relief in Gaza Province. FH has pioneered the model

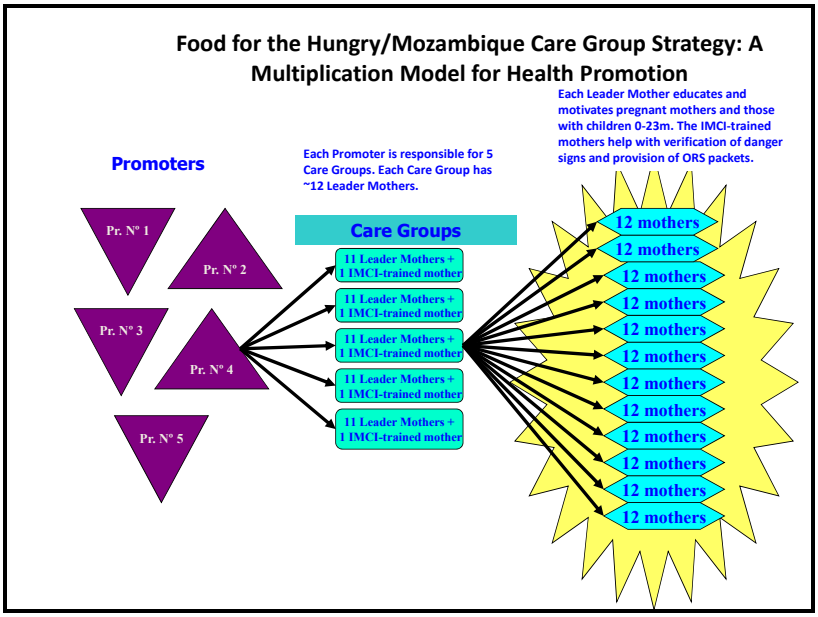
[4] Edward A, Ernst P, Taylor C, Becker S, Mazive E, Perry H. Examining the evidence of under-five mortality reduction in a community-based programme in Gaza, Mozambique. Trans R Soc Trop Med Hyg 2007 Aug;101(8):814-22.

Perry H, Sivan O, Bowman G, Casazza L, Edward A, Hansen K, Morrow M. Averting childhood deaths in resource-constrained settings through engagement with the community: an example from Cambodia. In: Gofin J, Gofin R, editors. Essentials of Community Health. Sudbury, MA: Jones and Bartlett.; 2010. p. 169-74.

See also the new website for Care Groups (www.caregroupinfo.org).

together with WR since that time and has helped to widely disseminate information about it. The Care Group structure in the project area made it possible to carry out the following activities:

- Select Care Group Volunteers, each trained to communicate educational messages to 12 other mothers in their immediate neighborhood;
- Organize these Care Group Volunteers (called Leader Mothers) into Care Groups with 12 members each to receive training and supervision from Promoters;
- Teach paid Promoters to train and supervise Care Group Volunteers to become behavior change agents;
- Employ a team of Supervisors to train, manage, and supervise Promoters and to problem solve within the target districts;
- Establish regular communication links among Care Group Volunteers, community leaders, staff at health facilities, MOH directors and staff, and the Project Management Team;
- Create a community-based health information system (C-HIS) and train Care Group Volunteers to report pregnancies, births, deaths, childhood illnesses, and cases of malnutrition to the Promoters, and for the Promoters to carry out a verbal autopsy when a child dies.
- Train one Care Group Volunteer per group in C-IMCI. (After two years, the project staff decided to train all CG Volunteers in C-IMCI.)


Food for the Hungry/Mozambique Care Group Strategy: A Multiplication Model for Health Promotion
Each Leader Mother educates and motivates pregnant mothers and those with children 0-23m. The IMCI-trained mothers help with verification of danger signs and provision of ORS packets.
Promoters
Each Promoter is responsible for 5 Care Groups. Each Care Group has ~12 Leader Mothers.
Care Groups
Pr. Nº 1
Pr. Nº 2
Pr. Nº 3
Pr. Nº 4
Pr. Nº 5
11 Leader Mothers + 1 IMCI-trained mother
11 Leader Mothers + 1 IMCI-trained mother
11 Leader Mothers + 1 IMCI-trained mother
11 Leader Mothers + 1 IMCI-trained mother
11 Leader Mothers + 1 IMCI-trained mother
12 mothers
12 mothers
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12 mothers

Figure 3. Structure of the Care Group Model

The Promoter met every two weeks with each Care Group and had five Care Groups

under his/her responsibility. The project trained five Supervisors, 65 Promoters, 4,095 Care Group Volunteers (in 325 Care Groups) to cover a population of 1.1 million people (Figure 3). The Promoters were all long-time residents of the villages and were based in the project area.

Each Supervisor (called an *Oficial*) supervised 15 Promoters. The Supervisors in turn were supervised by the project leadership team (Field Coordinator, Child Survival Project Coordinator, and the Monitoring and Evaluation Coordinator). The project had one vehicle that the project leadership team based in the city of Beira used to travel to and from the project area. Each of the five Supervisors had a motorbike, and each of the Promoters had a bicycle that was replaced annually because of wear and tear.

At the outset, the project leadership recruited five Supervisors (who had technical or professional training, such as in nursing or as a medical technician). They then began to work with local community leaders and the formal *Comite de Desenvolemento* (Development Committee) in each community to identify candidates for the Promoter position who were already living in the area who had at least five years of education and who could read and write and perform simple mathematical calculations. Seven Promoters were carried over from the Food for the Hungry previous Title II Project (which used Care Groups) nearby. The project had great difficulty in locating qualified women candidates. The majority of those hired as Promoters (85%) were men. Fortunately, in this context, Food for the Hungry had learned previously that male Promoters can be quite effective.

Once 30 Promoters had been hired, they were trained to serve as interviewers for the baseline KPC survey in Area A. Then, with the help of local community leaders and teachers, the Promoters gathered together all pregnant women and mothers of children aged 0-23m and registered all of them. In most communities, these women – in collaboration with the Promoters and community leaders – selected Leader Mothers (Care Group Volunteers) from among themselves. The Care Group operations research found that having the mothers choose their Leader Mothers appears to have decreased drop-out: of Leader Mothers in Area A, those who were elected by beneficiary mothers were 2.7 times more likely to serve for five years (compared to those who served 4 years or less) [OR = 2.7, CI: 1.19-5.99, p = 0.009].)

Then, the Supervisors and Promoters met together to learn the first module (entitled "Working with Communities"). There were altogether five educational modules (with more than one topic contained in some of the modules), each with 4-5 lessons. The Supervisors and Promoters met usually 3-4 times a year to learn a new module. It takes about 24-30 months to complete the entire educational cycle.

Every two weeks, each Care Group met with its Promoter for 1.5 to 2 hours. Leader Mothers had to walk on average 16 minutes to attend a Care Group meeting. At that time, the message learned during the previous two weeks was reviewed then they learned a new set of health messages. (Usually each lesson plan contained 3-4 key messages.) The Care Group Volunteers (Leader Mothers) informed the Promoter at the time of the Care Group meeting of any births or deaths that had occurred since the previous meeting.

Over the next two weeks, the Leader Mothers met with the 12 or so Beneficiary Mothers for which they were responsible. Over time, these Beneficiary Mothers changed. Once they no longer had a child 0-23 months of age, they "graduated" as a Beneficiary Mother and newly pregnant women or those with a newborn became a Beneficiary Mother. During home visits and group meetings, the Care Group Volunteer used a flipchart with pictures describing the message

being given.[5] About three-quarters of the time, the Leader Mother shared messages mostly or only in a group setting with beneficiary mothers. However, 27% of Leader Mothers shared messages only or mostly through individual home visits. Leader Mothers visited all Beneficiary Mothers who missed group meetings (defaulters) in their homes. Coverage with health promotion was very high. Over the life of the project, beneficiary mothers were asked (on six separate occasions) if they had received a visit from a Leader Mother in the past two weeks, and 92% (average; range = 87-95%) indicated that they had.

One Leader Mother in each Care Group was selected to receive five days of training in C-IMCI.[6] This provided her with additional knowledge and skills for prevention and treatment of childhood illness in the community. She was a resource to all the other Leader Mothers, particularly when they detected a mother or child that was sick or needed referral to a health facility because of the presence of danger signs. These C-IMCI Leader Mothers were often called on to confirm that a pregnant mother or child should be referred. They also kept a stock of ORS packets, which they provided to the other Leader Mothers when a child needed it.

At the time of each subsequent Care Group meeting, the Leader Mothers reported on the births and deaths that took place during the previous month. This information was part of the project's health information system. (This is described further in the section below on mortality assessment.)

One additional activity that arose as a result of the vital events registration and the verbal autopsies was home visits for newborns. The decision to include this activity arose after it became apparent from the vital events registration that neonatal deaths were an important proportion of deaths among children 0-23 months of age. According to the vital events reported by the Leader Mothers, neonatal deaths accounted for more than one-quarter of the deaths of children 0-23 months of age. The interventions designed initially for the project were not adequately addressing this. However, Leader Mothers later were asked to visit their pregnant Beneficiary Mothers as soon as possible after they had given birth – ideally on the day of birth – and then on a daily basis during the first week, three times during the second week, twice during the third week, and once during the fourth week. They received training in danger signs of neonates and had a checklist to follow (see Appendix 17), and counseled mothers during these visits using their flipcharts.

Principal Messages Employed

The health promotion messages focused on nutrition (including exclusive breastfeeding for the first six months of life, continued breastfeeding with appropriate complementary feeding for children 6-23 months of age, and rehabilitation of malnourished children with local foods); water treatment (point-of-use treatment with *Certeza*), sanitation and hygiene; dangers signs during pregnancy and among children for which health care should be sought; the need for routine preventive health services (immunizations and prenatal care), and the importance of giving birth at the nearest health center. Examples of pictorial and written messages for the nutrition module (including exclusive breastfeeding) are shown in Appendices 15 and 16.

[5] An example of this is shown in Annex 14. A complete copy of these educational modules (in Portuguese) is available from Food for the Hungry.

[6] The MOH had educational materials for this but they needed upgrading, so the project helped with this.

Hearth Program and Other Nutrition-related Interventions

The project had intended to hold Hearth[7] nutritional rehabilitation sessions for groups of malnourished children that had been identified with mid-upper-arm circumference (MUAC). However, there were not enough malnourished children in a local area to justify this (according to the CORE Group Hearth manual guidelines), so Care Group Volunteers (Leader Mothers) were taught how to work individually with the mothers of malnourished children using Hearth principles. In addition to this, all children 12-59 months of age received vitamin A capsules and de-worming medication. (Nutrition messages were also based, in part, on positive deviant practices identified during the Local Determinants of Malnutrition Study.)

Partnerships

The project worked in partnership with the MOH, particularly at the district level. District-level MOH staff were fully informed about the project's goals, objectives, and operational strategies. The project met monthly with each district MOH director and provided a report on project activities, including the number of deaths (by cause) and the number of home births. The project promoted the utilization of MOH services at Expanded Program on Immunization (EPI) outreach sites and Health Centers.

Collaboration with USAID and Its Mission in Mozambique

The project was in frequent contact by phone and email with USAID staff in Maputo. In 2007, two USAID/Maputo staff members visited the project (Dr. Titus Angi and Ms. Grace Garcia), and in 2009, two other USAID/Maputo staff visited (Ms. Maria da Conceicao Rodgriguez and Ms. Maria Pinto). Over the life of the project, there were six meetings in Maputo with USAID staff which were attended personally by the Project Manager. During the first three years, the project sent quarterly reports to USAID/Maputo; during the last two years it sent monthly reports. Annual reports were sent as well for each year of activity of the project.

The project's HQ backstop was in frequent contact by phone and email with the project's USAID Chief Technical Officers (CTOs) in Washington, DC. From 2005 to mid-2009 the CTO was Ms. Jill Boezwinkle and from 2009 until present the CTO has been Ms. Elaine Menotti. Ms. Nazo Kureshy, the Director of the CSHGP, Ms. Boezwinkle and Ms. Menotti have also interacted with the Food for the Hungry Senior Director of Health Programs, Mr. Tom Davis, at bi-annual technical conferences in Washington, DC, where the lessons learned and results of the project have been shared and discussed. The Project Child Survival Manager, Ms. Emma Hernandez, met in Maputo with Ms. Jill Boezwinkle in 2005 and Ms. Nazo Kureshy in 2008 at the request of USAID, to share information about the project.

Data Quality: Strengths and Limitations

The project staff members collected their own household survey data and analyzed the findings with support from the US HQ staff. Household interviews were conducted by Promoters, who usually had only a sixth grade education. They required considerable training,

[7] The Hearth model involves calling together groups of mothers of malnourished children and helping them to learn what locally foods are nutritious (from "positive deviant" mothers in the community who have well-nourished children) and then spend two weeks in daily educational sessions in which mothers bring these foods and prepare them as a group for their children. For further information, see http://coregroup.org/component/content/article/84 (accessed 2 August 2010).

but according to the project leaders they generally did a fine job of collecting quality data. The project provided close supervision of the data collection process and of the completed forms/questionnaires. The Promoters were able to conduct their interviews in the local language (Sena and Ndau) even though the questionnaires were in Portuguese and they wrote down the responses in Portuguese.

By the end of the project, the Promoters had had extensive experience in carrying out and recording the results of household interviews. The project learned to provide good training for the Promoters and to give clear instructions before going to the field to collect information.

At the time of the baseline KPC survey, field supervisors checked the data on the questionnaires at the end of every day. They found that generally fewer than 5% had significant problems. When the baseline KPC data was entered into the computer (using an EPI INFO Check File to minimize entry errors), 10% of all entries were checked by the M&E Coordinator, Ms. Cecilia Lopes. If there was any mistake identified, all of the questionnaires for that specific Promoter were reviewed.

There could possibly be several biases entering the findings. One is that the data collectors themselves (the Promoters) might have been biased by obtaining and recording answers that were more favorable for the project that might have actually been the case. The second bias is that respondents may have been biased by providing responses that they thought the interviewer (or the project) wanted to hear. (This bias could have also been operating to some degree in the focus group discussions.) But the question must also be asked – if an independent interviewer unassociated with the project arrived to conduct the same interview, would that person obtain information of better quality than that which the Promoters obtained? Without knowledge of the local language and some kind of trusted connection with the communities, it is hard to envision that outside independent interviewers could have obtained better data. In addition, many of the questions are such that it is hard for either the interviewer or the respondent to know the desired or preferred response is. Thus, it does not appear that bias had more than a minimal effect on the findings.

It should also be pointed out that following the baseline KPC survey, Promoters were always assigned to areas not in their normal supervisory jurisdiction to interview households (and collect anthropometric data) for the mini-KPC surveys and the final KPC survey. This certainly helped to reduce any potential for bias.

The mini-KPC surveys that the project carried out at least yearly provided confirming evidence that the interventions were effective and, as the Project Manager said, that "We were on the right track." The ongoing vital events registry and verbal autopsies provided information that led to a decision to add an activity. The importance of neonatal mortality had not been recognized prior to project implementation, and no interventions had been developed specifically to reduce neonatal mortality. As a result, the project developed a training module for this and included frequent home visits of the Leader Mother during the neonatal period as a new activity.

We have included in the project results data from the MOH regarding the changes in utilization of health facilities.

Project Results

Progress toward Quantitatively Defined Objectives

Overall, the progress in achievement of quantitatively defined end-of-project targets has been quite impressive, given the size of the target population and the logistical and socio-cultural

challenges faced within the project area. Even more impressive has been the rapid progress in increased indicator coverage. At the time of the mid-term evaluation (MTE), six of the nine measured indicators had already been achieved in Area A. By June 2010, eight out of 12 targets set by the project in Area A and nine of the 12 targets for Area B had been achieved (see Figures 4-7 and Tables 4-5).

With respect to the project targets that were not achieved, only two were not close to being achieved. This was the percentage of children who had consumed a vitamin-A rich food during the previous 24 hours (60% vs. a target of 80% in Area A and 67% vs. 80% in Area B). In Area B, 82% of children had been weighed versus a target of 90%. However, both indicators showed marked improvements compared to baseline levels (31 and 26 percentage points for vitamin A consumption in Areas A and B respectively and 17 percentage points for weighings in Area B). The remaining two targets were within four percentage points or less of achieving their goal.

There were substantial improvements in child nutrition among children 0-23 months of age as measured by weight for age (Figures 8 and 9). In both Areas A and B, the percentage of children who were 2 standard deviations or more below the mean weight-for-age indicator declined by one-quarter in Area A and one-third in Area B. The decline in Area B was statistically significant and the decline in Area A just missed statistical significance. The declines in prevalence of severe malnutrition (Figure 9) were even more pronounced and again the difference in Area B was statistically significant.

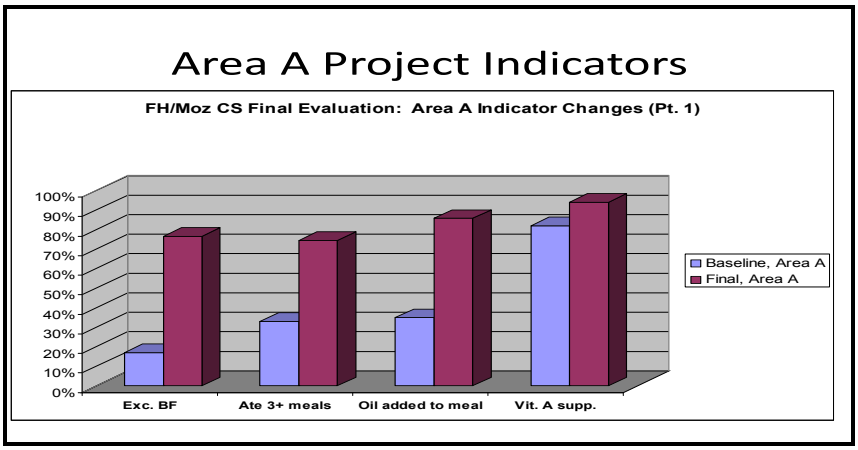
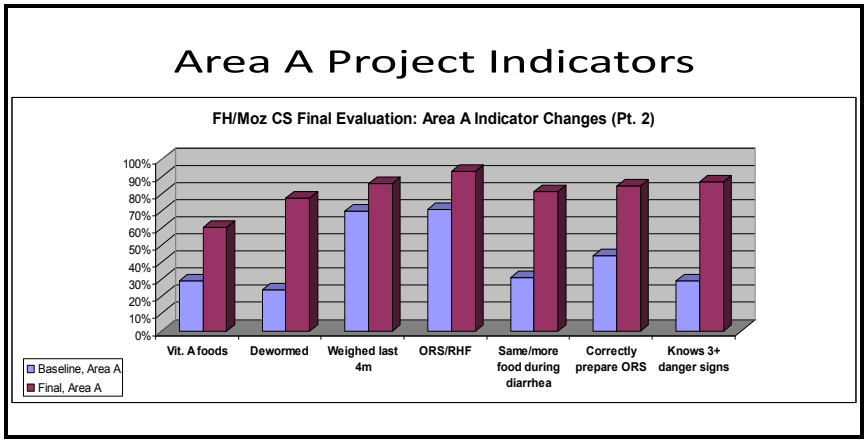


Figure 4.



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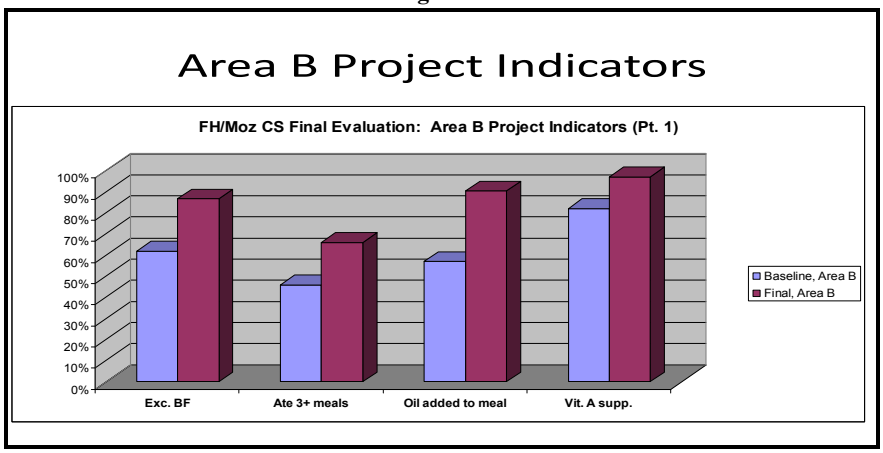

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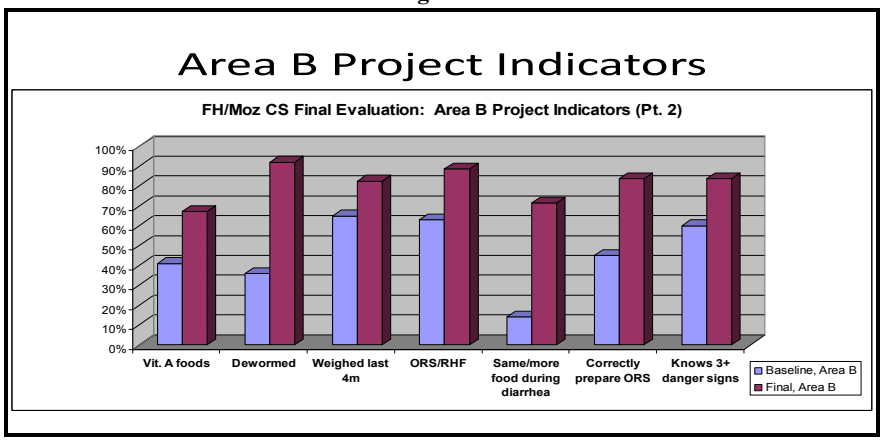

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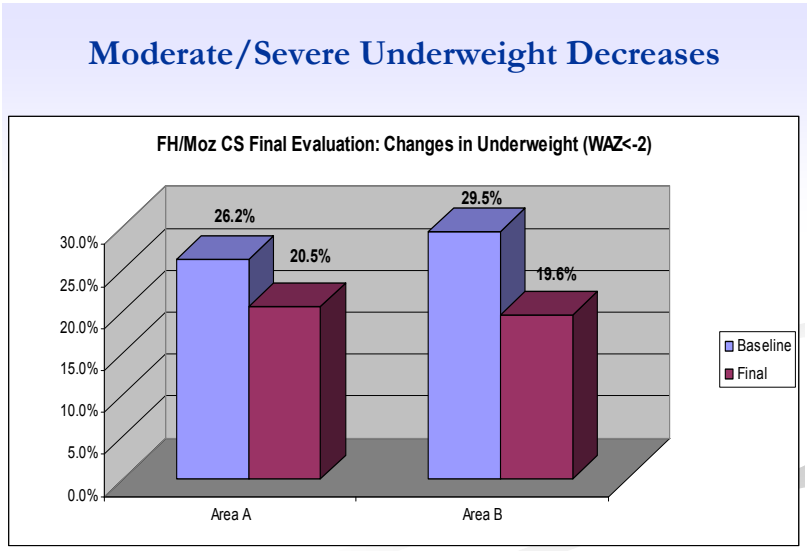
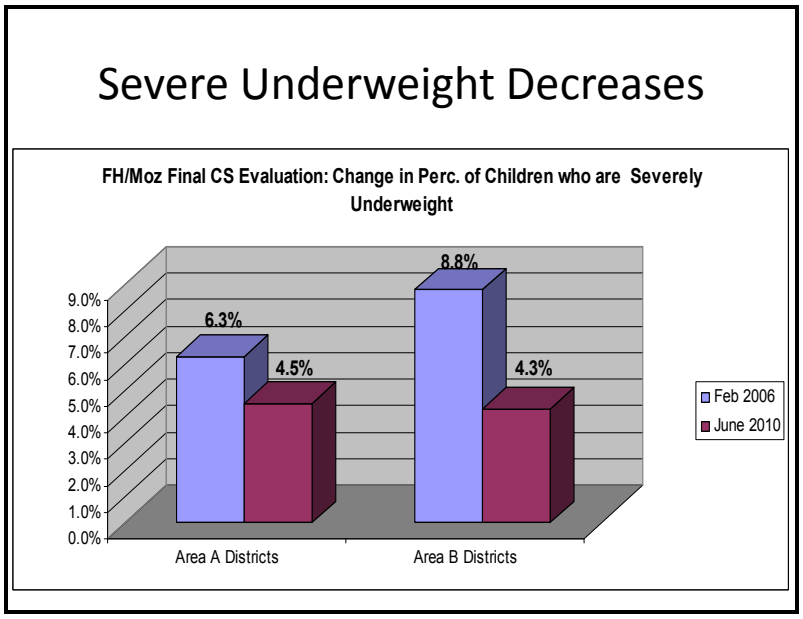


Figure 8.



Note: Differences in Area B (but not in Area A) are statistically significant ($p<0.05$)

Figure 9.

Table 4. Progress in Achievement of End-of-Project Targets, Area A

#	Project Indicators	Baseline				Endline				Project target	Target achieved?
		Numer-ator	Denom-inator	Percent-age	Confidence interval	Numer-ator	Denom-inator	Percent-age	Confidence interval		
1	% of children 0-23m who are underweight (WAZ<-2.0)	146	557	26.2%	22.6-30.1%	117	571	20.5%	17.2-23.8%	18%	no
2	Percentage of infants aged 0-5m who were fed breast milk only in the last 24 hours	9	52	17%	8.2-30.3%	36	47	76.6%*	62.0-87.7%	60%	yes
3	Percentage of children 9-23m who receive food other than liquids at least three times per day	40	123	33%	24.4-41.6%	88	118	74.6%*	65.7-82.1%	65%	yes
4	Percentage of children 6-23m with oil added to their weaning food	50	142	35%	27-43%	127	148	85.8%*	79.1-91.0%	80%	yes
5	Percentage of children 12-23m who have received one Vitamin A capsule in the past six months (card or mother's report)[8]	83	101	82%	73.3-89.1%	95	101	94.1%	87.5-97.8%	95%	no
6	Percentage of children 6-23m who have consumed at least one Vitamin A rich food in the previous day	42	147	29%	21.4-36.6%	91	151	60.3%*	52.0-68.1%	80%	no
7	Percentage of children 12-23 months who received de-worming medication in the last six months	24	99	24%	16.2-33.9%	62	80	77.5%*	66.8-86.1%	75%	yes
8	Percentage of children aged 0-23m who were weighed in the last four months (card-confirmed)	129	184	70%	63-77%	150	198	86.2%*	81.1-91.3%	90%	no

[8] At baseline, for card confirmed only, this was 58% (59 of 101). By mother's report only, this was 78% (79 of 101).

#	Project Indicators	Baseline				Endline				Project target	Target achieved?
		Numer-ator	Denom-inator	Percent-age	Confidence interval	Numer-ator	Denom-inator	Percent-age	Confidence interval		
9	Percentage of children aged 0-23m with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids (RHF)	57	80	71%	60-81%	42	45	93.3%*	81.7-98.6%	90%	yes
10	Percent of children aged 0-23m with diarrhea in the last two weeks who were offered the same amount or more food during the illness	25	80	31%	21-43%	35	43	81.4%*	69.8-93.0%	60%	yes
11	Percentage of mothers of children 0-23m who can correctly prepare ORS	88	199	44%	37.2-51.4%	167	197	84.8%*	79.0%-89.5%	80%	yes
12	Percentage of mothers of children age 0–23m who know at least two signs of childhood illness that indicate the need for treatment	149	199	75%	68.3-80.7%	193	198	97.5%*	94.2-99.2%	n/a (see below; changed during DIP)	n/a
12b	Percentage of mothers of children age 0–23m who know at least three signs of childhood illness that indicate the need for treatment	58	199	29%	22.8-35.5%	172	198	86.9%*	82.2-91.6%	75%	yes
13	The MOH in at least one other Mozambican province requests assistance (during the life of the program) from FH to expand the Care Group model into their geographical area. OR is conducted on the reasons	-	-	-	-	-	-	Achieved (CGs being used in Cabo Delgado); CG OR conduct-ed May 2010)	-	One Province	yes

#	Project Indicators	Baseline				Endline				Project target	Target achieved?
		Numer-ator	Denom-inator	Percent-age	Confidence interval	Numer-ator	Denom-inator	Percent-age	Confidence interval		
	for Care Group effectiveness.										
14	Percentage of Leader Mothers trained in community-IMCI modules who score 80% or higher on an IMCI QI checklist.	-	-	n/a	-	40	41	97.6%	92.8-100%	80%	yes
15	Percentage of Leader Mothers who score 80% or higher on the Health Promotion checklist (QIVC). [Three month average]	-	-	n/a	-	184	228	80.7%	75.6-85.8%	80%	Yes
16	Percentage of first-phase Care Groups in Area A that continue to meet and do health promotion following the reduction in the number of Promoters in Year 2.5.							100%, but there was no reduct-ion in the # of Promo-ters		90%	n/a

*Statistical significance <0.05

Table 5. Progress in Achievement of End-of-Project Targets, Area B

#	Project Indicators	Baseline				Endline				Project target	Target achieved?
		Numer-ator	Denom-inator	Percent-age	Confidence interval	Numer-ator	Denom-inator	Percent-age	Confidence interval		
1	% of children 0-23m who are underweight (WAZ<-2.0)	171	580	29.5%	25.8-33.4%	113	578	19.6%*	16.3-22.8%	18%	yes
2	Percentage of infants aged 0-5 months who were fed breast milk only in the last 24 hours	33	53	62%	47.9-75.2%	39	45	86.7%	73.2-94.9%	60%	yes
3	Percentage of children 9-23m who receive food other than liquids at least three times per day	60	130	46%	37.4-55.1%	84	127	66.1%*	57.2-74.3%	65%	yes
4	Percentage of children 6-23m with oil added to their weaning food	86	151	57%	48.7-65%	134	148	90.5%*	85.8-95.3%	80%	yes
5	Percentage of children 12-23m who have received one Vitamin A capsule in the past six months (card or mother's report)[9]	85	104	82%	72.9-88.6%	96	99	97%*	91.4-99.4%	95%	yes
6	Percentage of children 6-23m who have consumed at least one vitamin A-rich food in the previous day	65	157	41%	33.6-49.5%	103	153	67.3%*	59.3-74.7%	80%	no
7	Percentage of children 12-23 months who received de-worming medication in the last 6m	35	98	36%	26.3-46%	70	76	92.1%*	83.6-97.0%	75%	yes
8	Percentage of children aged 0-23m who were weighed in the last 4m (card confirmed)	119	183	65%	57.6-71.9%	132	160	82.5%*	76.6-88.4%	90%	no

[9] For card confirmed only, this was 58% (59 of 101). By mother's report only, this was 78% (79 of 101).

#	Project Indicators	Baseline				Endline				Project target	Target achieved?
		Numer-ator	Denom-inator	Percent-age	Confidence interval	Numer-ator	Denom-inator	Percent-age	Confidence interval		
9	Percentage of children aged 0-23m with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids (RHF)	54	86	63%	51.7-73%	39	44	88.6%*	75.4-96.2%	90%	No
10	Percent of children aged 0-23m with diarrhea[10] in the last two weeks who were offered the same amount or more food during the illness	28	204	14%	9.3-19.2%	30	42	71.4%*	57.8-85.1%	60%	Yes
11	Percentage of mothers of children 0-23m who can correctly prepare ORS	93	209	45%	37.6-51.5%	167	199	83.9%*	78.1-88.7%	80%	Yes
12	Percentage of mothers of children age 0-23m who know at least two signs of childhood illness that indicate the need for treatment	172	211	82%	75.6-86.5%	194	199	97.5%*	94.2-99.2%	n/a (changed indicator during DIP)	n/a
12b	Percentage of mothers of children age 0-23m who know at least three signs of childhood illness that indicate the need for treatment	126	211	60%	52.8-66.4%	167	199	83.9%*	78.8-89.0%	75%	Yes
13	The MOH in at least one other Mozambican province requests assistance (during the life of the program) from FH to expand the Care Group model into their geographical area. OR is conducted on the reasons for Care Group effectiveness.	-	-	-	-	-	-	Achieved (CS in use in Cabo Delgado; CG OR conduct-ed May 2010)	-	One pro-vince	yes

[10] At baseline, this was calculated for any illness in the past two weeks. At the time of the final KPC evaluation survey , this was calculated for diarrhea.

#	Project Indicators	Baseline				Endline				Project target	Target achieved?
		Numer-ator	Denom-inator	Percent-age	Confidence interval	Numer-ator	Denom-inator	Percent-age	Confidence interval		
14	Percentage of Leader Mothers trained in community-IMCI modules who score 80% or higher on an IMCI QI checklist.	-	-	n/a	-				(see Area A; not measured in Area B)	80%	n/a
15	Percentage of Leader Mothers who score 80% or higher on the Health Promotion checklist (QIVC). [Three month average]	-	-	n/a	-	194	323	60.1%	54.7-65.4%	80%	no
16	Percentage of first-phase Care Groups that continue to meet and do health promotion following reduction of health Promoter staff in Year 2.5.							n/a (applies to Area A only)			n/a

*Statistical significance <0.05

Progress in Quantitatively Defined Indicators Which Were Not Project Objectives

Figures 10-13 and Tables 6 and 7 present the findings for progress in RapidCATCH indicators, that were not project objectives but for which the Child Survival and Health Grants Programs requires measurement for reporting to the US Congress. In Area A, nine of the 11 RapidCATCH indicators that were not established indicators demonstrated a statistically-significant positive increase as did nine of the 11 in Area B. The median increase for these indicators was 24 percentage points in Area A and 19 percentage points in Area B. There appears to be a decline in complete immunization coverage in both Areas A and B. It fell by nine percentage points in Area A and by 21 percentage points (a statistically significant decrease) in Area B. The project had no direct role in immunizations, but it did promote utilization of immunization services provided at EPI outreach sites. The reasons for decline in complete immunization coverage in children while measles and tetanus toxoid coverage increased are not clear. Perhaps one of the most impressive achievements of the project was the increase in insecticide-treated bednet utilization by 45 percentage points in Area A and a whopping 71 percentage points in Area B.

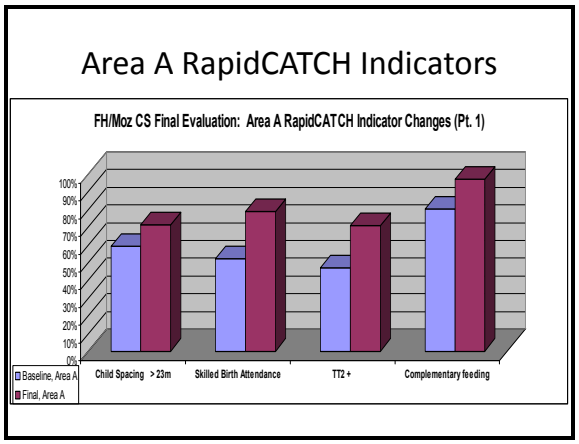


Figure 10.

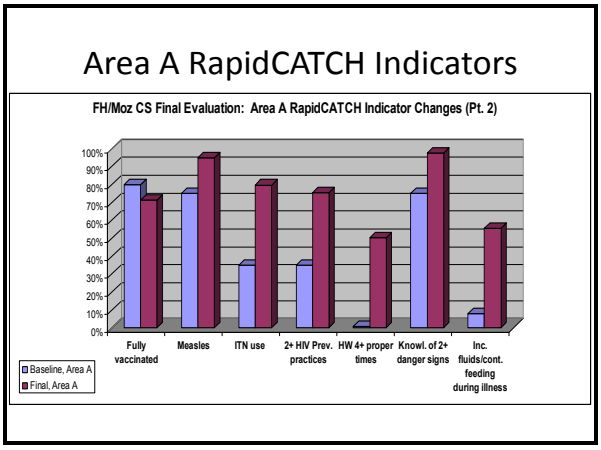


Figure 11.

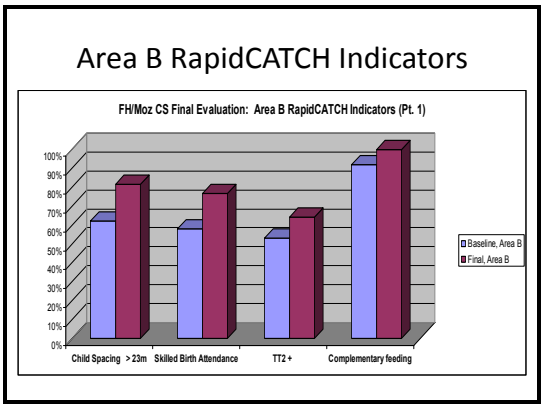


Figure 12.

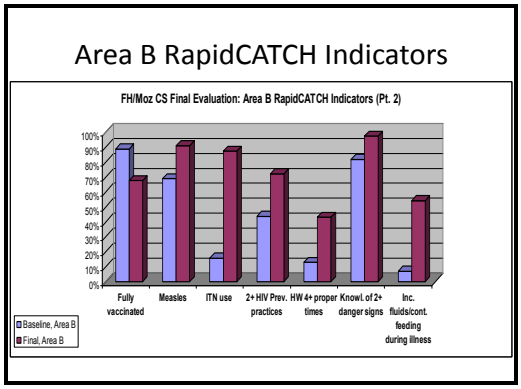


Figure 13.

Table 6. RapidCATCH Indicators for Area A

#	Project Indicators	Baseline				Endline			
		Numer-ator	Denom-inator	Percent-age	Confidence interval	Numer-ator	Denom-inator	Percent-age	Confidence interval
1	% of children 0-23m who are underweight (WAZ<-2.0)	146	557	26.2%	22.6-30.1%	117	571	20.5%	17.2-23.8%
2	Percentage of children age 0-23m who were born at least 24 months after the previous surviving child	54	91	59%	48.5-69.5%	75	105	71.4%	61.8-79.8%
3	Percentage of children age 0-23m whose births were attended by skilled health personnel	103	199	52%	44.6-58.9%	154	196	78.6%*	72.2-84.1%
4	Percentage of mothers with children age 0-23m who received at least two TT injections before the birth of their youngest child	94	199	47%	40.0-54.0%	139	196	70.9%*	64.0-77.2%
5	Percentage of infants aged 0-5m who were fed breast milk only in the last 24 hours	9	52	17%	8.2-30.3%	36	47	76.6%*	62.0-87.7%
6	Percentage of children age 6-9m who received breast milk and complementary foods during the last 24 hours	24	30	80%	61.0-92.0%	33	34	97.1%	84.7-99.9%
7	Percentage of children age 12-23m who are fully vaccinated (against the 5 vaccine-preventable diseases) before the first birthday	73	91	80%	71.0-88.0%	72	101	71.3%	61.4-79.9%
8	Percentage of children age 12-23m who received a measles vaccine	75	100	75%	65.0-83.0%	76	80	95%*	90.2-99.8%
9	Percentage of children age 0-23m who slept under an insecticide-treated net (in malaria risk areas) the previous night	69	199	35%	28.0-42.0%	158	198	79.8%*	73.5-85.2%
10	Percentage of mothers with children age 0-23m who cite at least two known ways of reducing the risk of HIV infection	69	199	35%	28.0-42.0%	148	196	75.5%*	69.5-81.%
11	Percentage of mothers with children age 0-23m who report that they wash their hands with soap/ash before [4 times]	2	199	1%	0.1-34%	100	198	50.5%*	43.3-57.7%
12	Percentage of mothers of children age 0-23m who know at least two signs of childhood illness that indicate the need for treatment	149	199	75%	68.3-80.7%	193	198	97.5%*	94.2-99.2%
13	Percentage of sick children age 0-23m who received increased fluids and continued feeding during an illness in the past two weeks	13	167	8%	4.0-13.0%	25	45	55.6%*	40.0-70.4%

*Statistical significance <0.05

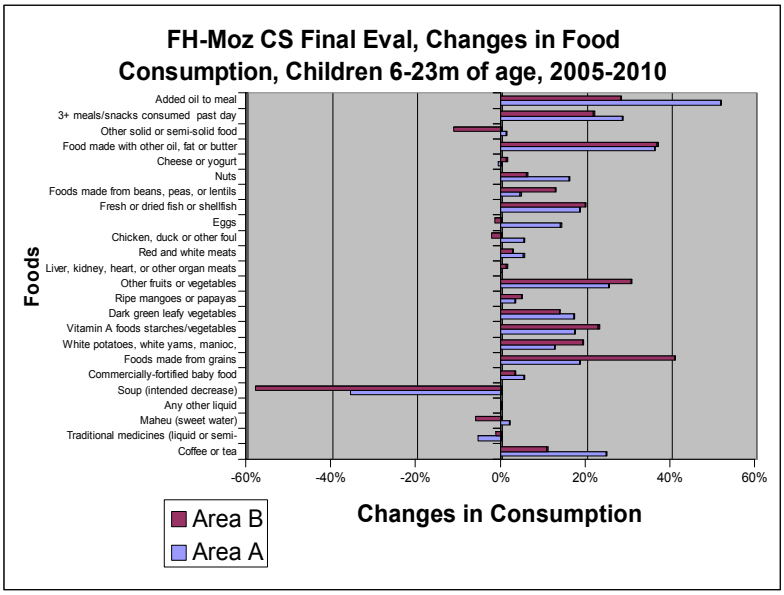
Table 7. RapidCATCH Indicators for Area B

#	Project Indicators	Baseline				Endline			
		Numer-ator	Denom-inator	Percent-age	Confidence interval	Numer-ator	Denom-inator	Percent-age	Confidence interval
1	Percentage of children 0-23m who are underweight (WAZ<-2.0)	171	582	29.4%	26.4-34.5%	113	582	19.4%*	16.2-22.6%
2	Percentage of children age 0-23m who were born at least 24 months after the previous surviving child	58	93	62%	51.7-72.2%	92	113	81.4%*	73.0-88.1%
3	Percentage of children age 0–23m whose births were attended by skilled health personnel	120	207	58%	50.9-64.8%	152	198	76.8%*	70.3-82.5%
4	Percentage of mothers with children age 0–23m who received at least two TT injections before the birth of their youngest child	110	207	53%	46.1-60.1%	127	198	64.1%	57.0-70.8%
5	Percentage of infants aged 0-5m who were fed breast milk only in the last 24 hours	33	53	62%	47.9-75.2%	39	45	86.7%	73.2-94.9%
6	Percentage of children age 6-9m who received breast milk and complementary foods during the last 24 hours	35	38	92%	78.6-98.3%	28	28	100%	87.7- 100.0%
7	Percentage of children age 12-23m who are fully vaccinated (against the 5 vaccine-preventable diseases) before the first birthday[11]	93	104	89%	81.9-94.6%	67	99	67.7%*	57.5-76.7%
8	Percentage of children age 12-23m who received a measles vaccine	70	101	69%	59.3-78.1%	80	98	91.3%*	85.1-97.4%
9	Percentage of children age 0-23m who slept under an insecticide-treated net (in malaria risk areas) the previous night	33	211	16%	11-21.3%	174	199	87.4%*	82.0-91.7%
10	Percentage of mothers with children age 0-23m who cite at least two known ways of reducing the risk of HIV infection	92	207	44%	37.6-51.5%	143	198	72.2%*	66.0-78.5%
11	Percentage of mothers with children age 0–23 months who report that they wash their hands with soap/ash before [4 times]	27	211	13%	8.6-18.1%	86	199	43.2%*	36.2%-50.4%
12	Percentage of mothers of children age 0–23m who know at least two signs of childhood illness that indicate the need for treatment	172	211	82%	75.6-86.5%	194	199	97.5%*	94.2-99.2%
13	Percentage of sick children age 0-23m who received increased fluids and continued feeding during an illness in the past two weeks	15	211	7%	4-11.5%	24	44	54.5%*	38.8-69.6%

*Statistical significance <0.05

[11] *At baseline, calculated on each of five vaccines. At final, calculated on DTP3 + measles as proxies.*

The project also collected information on the types of healthy complementary foods consumed by children 6-23 months of age during the previous 24 hours (see Fig. 14). A striking improvement can be seen in both Areas A and B. There was a statistically significant increase in 59% of the 17 food groups in Area A (with an average improvement of 10 percentage points) and a significant increase in 38% of the groups in Area B (with an average increase of 8 percentage points). There was a marked decrease in consumption of soups (which were considered to lack nutrient density). The increase in "coffee or tea" is considered to represent exclusively an intake in tea since coffee is not consumed in the area.



Note: Percentage of mothers who reported that their child consumed one of the types of foods in the previous 24 hours.

Figure 14.

Evidence Regarding Utilization of Ministry of Health Facilities

Among the many activities of the project was the promotion of the utilization of MOH facilities for prenatal care and institutional births. Data on facility utilization were obtained from the Provincial office of the MOH. Figures 15-17 show the increases in utilization in the Area A project districts compared to three districts in Sofala Province where the project was not working. The number of initial prenatal consultations, follow-up prenatal consultations, and facility births increased by 76%, 94% and 172%, respectively in the Area A MOH facilities while in the comparison districts the increases were much less (13%, 15%, and 50%, respectively).

Since women who come for prenatal care visits receive an insecticide-treated bednet (ITN), the marked increase in ITN usage that was observed in the RapidCATCH indicators can be attributed to increased community mobilization and a subsequent increased utilization of prenatal care at health facilities. The women also received intermittent preventive treatment for malaria, as well, at the time of their prenatal visit.

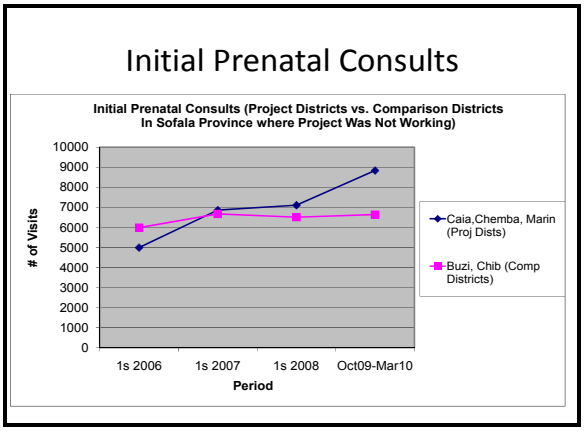


Figure 15.

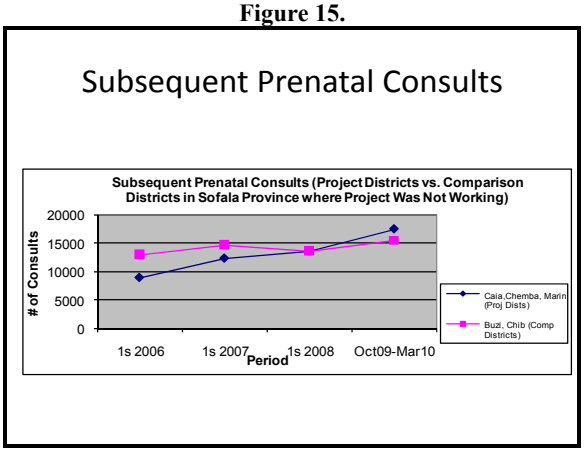


Figure 16.

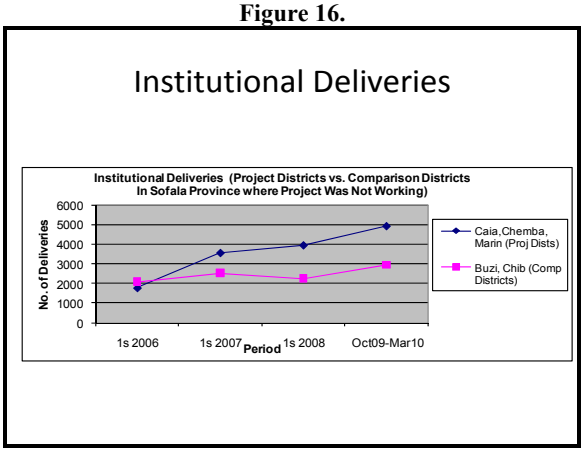


Figure 17.

Qualitative Evidence of Progress in Achievement of Project Objectives

A total of 17 focus group discussions (FGDs) were carried out with community leaders, beneficiary mothers, and Leader Mothers. There was intense competition among the Promoters for the Evaluation Team to visit their community because they were all so proud of what they had accomplished. Consequently, communities were selected at random for a field visit. In addition, we interviewed five Promoters and one MOH District Director. The results from the May 2010 Care Group Operations Research were also considered, which was based on 30 focus groups with Leader Mothers, beneficiary mothers, community leaders and Promoters followed by individual interviews with 200 Leader Mothers, 200 beneficiary mothers, and all Promoters. A summary of themes that emerged from the August 2010 FGDs and interviews follows.

Overall, there were repeated statements that community leaders, beneficiary mothers, leader mothers, and project staff were highly pleased with the project and its achievements. There is a common perception that children have fewer illnesses, are better nourished, and are less likely to die. The respondents reported that there were no major problems in understanding or implementing educational messages aside from some occasional individuals resisting certain messages or some difficulties at the outset in understanding some of the messages.

Repeated statements were made by community leaders and by others interviewed indicating that the community leaders were supportive of the project and its work and they were always ready to help the Leader Mothers when they encountered a difficult situation in the community that they needed help with.

We heard many comments that supported the following themes, and we heard no comments that contradicted these themes:

- There has been an increase in the utilization of health facilities[12] for danger signs, growth monitoring, prenatal care, and childbirth;
- There have been marked improvements in the households in terms of cleanliness, handwashing with soap/ash, building and maintaining latrines, building and using drying racks for dishes and cooking pots, garbage disposal, "tippy taps,"[13] and child feces disposal;
- There has been a marked increased in the use of specific nutritious foods for children after six months of age;
- Administration of colostrum immediately after birth and the provision of exclusive breastfeeding during the first six months of life has become the standard practice in the community;
- In the Care Group Operations Research study, project staff found that 61% of Care Group volunteers (Leader Mothers) who served as the main volunteers in the program said that their husbands respect them more now. 64% said their community leaders respect them

[12] The local terminology for the health center is a "hospital" even though these facilities are not formally hospitals. They do have some beds but no x-ray or surgical facilities.

[13] "Tippy-taps" are plastic containers that hang from a tree and have a small opening from which water can be poured for handwashing. A bar of soap is hanging alongside for ready access. The project promoted these, as shown in the photograph in Appendix 22.

more, 25% said health staff at the clinics respect them more, and 100% said other women and mothers respect them more now. This may be a part of the reason that spousal abuse appears to be much lower now among these Care Group volunteers (3%) as compared with other women in their communities (~34%). Spousal abuse in both groups appears to have decreased during the project (from 69% in a study done in 2004 to 34% in this 2010 OR study). Care Group volunteers also said that they respect their husbands more now, so mutual respect appears to be growing. (In Mozambique as a whole, about 55% of women say that they think it is okay for a man to hit a woman.)

- The husbands are happy that their wives are learning new and helpful things, that their houses are clean, and that their children are healthier;
- We heard in a number of different comments similar to the following: "This is the first time that we have seen a project like this – the others just gave us things."
- The Leader Mothers and Beneficiary Mothers reported that they expected that they would continue many of their community activities, but not all will do so in as organized or as frequent a manner. Most Leader Mothers said they plan to continue visiting mothers of young children and pregnant women. Some said they plan to continue meeting together as Leader Mothers in the Care Group.

Another important finding that arose from the interviews and FGDs is that all perceived the quality of care provided at the health facilities to be good. We did not hear any complaints about the services provided there.

The only significant complaint that was expressed several times was that the Beneficiary Mothers were sometimes jealous of the Leader Mothers because they had special *capulanas* (skirts) and that they themselves would like to have one. Sometimes Beneficiary Mothers were suspicious that the Leader Mothers had received *capulanas* for the Beneficiary Mothers but had never delivered the *capulanas* to the Beneficiary Mothers, and others accused the Leader Mothers of taking advantage of the children of Beneficiary Mothers in order to receive the benefit of the *capulanas.*

Since the villages we visited during this final evaluation were randomly selected, some ended up being quite far from the main road. One was 40 km from the nearest health facility (a 12-hour walk), and another was a 6-hour walk away. Thus, access to facility-based health care services is quite limited for parts of the project population.

Evidence Related to Under-5 Mortality Reduction and LiST and Cost Effectiveness

Here we present the evidence related to declines in under-5 mortality as a result of project activities. We provide both indirect and direct estimates.

Using the LiST Tool, which produces an indirect estimate based on changes in coverage of key child survival interventions, the project saved a total of 6,848 lives of children 0-59 months of age. If subtracting out the decline in mortality that we estimate would have occurred in the absence of the project (see Table 8), 4,590 lives were saved. Details about the LiST tool and how these estimates were obtained are contained in Appendix 14.

Table 8. Uncorrected and Corrected Estimates of Lives Saved using the LiST Tool

Districts (Sofala Province)	Number of beneficiaries	Estimated number of lives saved (*corrected*)	Estimated number of lives saved (***uncorrected***)
Area A (Caia, Chemba, Manga, and Marringue Districts), March 2006-June 2010	70,022	3,238	5,032
Area B (Dondo, Gorongosa, and Nhamatanda Districts), March 2009 –June 2010	96,697	1,352	1,816
All 7 Districts	**219,617**	**4,590**	**6,848**

A direct estimate of reduction of mortality is possible because the Leader Mothers reported on a monthly basis during the Care Group meetings the number of births and deaths (by age) that took place during the previous month. Unfortunately, this activity did not begin in Area A until one year after the project began, so it is not possible to directly measure baseline levels of mortality at the time project activities began. (It also appears [from data for Area B] that most of the mortality impact happens during the first year of Care Group projects.) However, in Area B vital event registration began at the outset of project activities. However, it appears that only about 10% of the expected births and deaths were picked up by this system. A full analysis of this data is included in Annex 14. Nevertheless, a crude estimate from these data is that 6,598 child deaths were averted as a result of project activities (which is within 4% of the uncorrected estimate of lives saved shown in Table 8).

Cost-Effectiveness

With these mortality estimates in hand, we can now estimate various indicators of cost-effectiveness (Table 9). **Based on the uncorrected estimate of lives saved,[14] the USAID cost per life saved in $441, the USAID cost per DALY averted is $14.72, and the cost per beneficiary per year (USAID + match funds) is $2.78.** Further details about these calculations are contained in Appendix 14.

Table 9. Corrected Estimates of Cost-Effectiveness of Project Using the LiST Tool*

Districts (Sofala)	Estimated number of lives saved (*uncorrected*)	Project costs	Cost per life saved	Cost per DALY averted*	Total cost per beneficiary per year
Area A (Caia, Chemba, Manga, and Marringue Districts), March 2006-June 2010	5,032	$2,026,191	$403	$13.42	
Area B (Dondo, Gorongosa, and Nhamatanda Districts), March 2009 –June 2010	1,816	$997,975	$549.55	$18.32	
All 7 Districts	**6,858**	**$3,024,166**	**$441**	**$14.72**	**$2.78**

*Underlying secular trends in child mortality reduction have been subtracted out to produce an estimate attributable to the project.

[14] We have used the uncorrected estimate given that most projects report these numbers in CSHGP final evaluations rather than the corrected estimates.

Table 10 compares the impact and costs of the current project with other Care Group child survival projects and the overall indirect estimate of mortality decline for all USAID-funded child survival projects. **Overall, the current project has reached twice as many beneficiaries as any other Care Group child survival project to date, and it has the lowest average cost per beneficiary per year, has saved more than five times as many lives as any other Care Group project at the lowest cost per life saved and the lowest cost per DALY averted.**

A previous analysis[15] of estimated lives saved in child survival projects (using the Bellagio Lives Saved Calculator (BLSC), a precursor to the LIST) for 32 projects funded by the USAID Child Survival and Health Grants Program found that the average number of lives saved was 883, with an average 25% reduction in the U5MR and an average USAID cost per life saved of $1,293. A recent comparison of six USAID-funded Care Group projects found that an estimated 858 lives were saved on average by these projects (with a range of 530-1063), with an estimated 27% decline in the U5MR. (The USAID, CSHGP Portfolio Highlights report on Grantees Save Lives in 2008 found an average decline of 14%.) **Thus, this current project is the most cost-effective USAID-supported child survival project reported to date.**

Table 10. Cost-Effectiveness of the Current Project with Other USAID-financed Child Survival Care Group and Other Projects (Based on Bellagio Lives Saved Calculator Data, Uncorrected for Secular Trends)

Child Survival Project	Estimated % reduction in U5M	Number of beneficiaries*	Total project cost**	Average cost per beneficiary per year	Estimat-ed number of lives saved	Cost per life saved	Cost per DALY averted
FH/ Mozambique (2005-2010)	30% overall (32% in Area A & and 26% in Area B)	219,617	$3,024,166	$2.78	6,848	$441	$14.72
World Relief Vurhonga IV	33%	101,757	$2,000,000	$6.56	1,217	$1,643	$54.77
World Relief/ Vurhonga II	48%	53,418	$1,397,531	$6.54	769	$1,817	$60.57
World Relief/ Vurhonga I	33%	57,277	$1,811,895	$7.91	819	$2,212	$27.30
World Relief/ Rwanda	29%	54,451	$1,733,333	$6.37	676	$2,564	$85.47
World Relief/ Malawi I	32%	68,917	$1,333,335	$4.84	557	$2,394	$79.80
World Relief/ Malawi II	28%	72,226	$2,022,034	$7.00	537	$3,773	$125.77
Plan/Kenya	26%	110,735	$2,300,000	$4.15	826	$2,785	$92.82
Average of 8 Care Group projects above	30%	92,300	$1,956,016	$5.77	1,531	$2,204	$67.65
Average of recent USAID-	14%						

[15] Ricca, James (2008). Presentation to the USAID Global Health Bureau, "CSHGP MNCH projects consistently demonstrate high impact at low cost with community-focused approaches."

Child Survival Project	Estimated % reduction in U5M	Number of beneficiaries*	Total project cost**	Average cost per beneficiary per year	Estimat-ed number of lives saved	Cost per life saved	Cost per DALY averted
supported child survival project***							

* Number of women of reproductive age and children 0-59m of age served by the project.
** USAID expenses plus matching funds provided by the NGO.
***USAID, CSHGP Portfolio Highlights: Grantees Save Lives, 2008.
Source of USAID Child Survival and Health Grants Program PVO project data: Project Final Evaluations and personal communications with World Relief, Food for the Hungry and Plan International child survival staff (October 2010)

In summary, there is strong evidence that the project has reduced under-five mortality and saved the lives of many children. Providing an accurate measure of exactly by how much mortality declined and exactly how many lives were saved as a result of project activities remains a challenge. Depending on the measures used and what assumptions were made, it appears that the under-five mortality rate fell by at least 30% and that the number of lives saved appears to be in the range of at least 4,590-6,848 children. These mortality impact estimates are reinforced by the strong evidence of marked increases in coverage of interventions that are known to reduce under-5 mortality. The repeated comments from participants in the FGDs that the number of children dying has declined markedly since the project began its activities also reinforce these conclusions.

Discussion of Results

Contribution toward Objectives

This project has abundant evidence of success in achieving its overall goals and objectives. We have strong qualitative and quantitative evidence of improvement of mortality among children 0-23 months of age, and we have strong evidence of improved coverage of interventions that reduce morbidity and mortality in mothers and children. Among the most important of these for mothers are increased utilization of facilities for prenatal care and childbirth, increased birth spacing, and increased utilization of ITNs. Among the most important of these for children are improved nutritional status, increased coverage of practices that prevent and improve the case management of diarrhea, increased utilization of ITNs (which prevent cases of malaria in mothers and children), increased utilization of health facilities when pregnant women and children develop danger signs, and increased maternal tetanus toxoid immunization coverage. The training of 4,095 Leader Mothers and, in addition, 325 Leader Mothers with special training in C-IMCI has provided all mothers with ready access to knowledge and advice. Finally, we directly observed at the time of focus group discussions during the final evaluation that the Care Group model has brought knowledge, skills, tools and passion needed for effective and sustainable community health development, and that these are highly likely to continue after the project ends later this year.

How Were These Results Achieved?

Many elements were essential for the achievement of the above results. Among them, the most important were the Care Group model, the quality of the project leadership and staff, and the engagement of communities and women as partners.

The Care Group Model[16]

The Food for the Hungry staff first developed experience with the Care Group model initially in its Title II project in Sofala province from 1996 until 2004. Because of the demonstrated success of the Care Group Model in previous child survival projects, the approach has spread to many other settings around the world. The most recent estimate is that 20 different organizations have used the Care Group Model in at least 20 different countries.[17] Evidence for its effectiveness in reducing under-5 mortality has been reported in a peer-reviewed journal[18] and highlighted in the 2008 UNICEF State of the World's Children report.[19] The achievements of the current project once again demonstrate the robustness and resilience of the Care Group model on a larger scale. The growing number of organizations using the Care Group model in an increasing number of countries is a testimony to the effectiveness of the approach.

The rapid uptake of interventions that the project achieved in both Areas A and B has been repeatedly shown in other implementations of the Care Group model. Although we didn't present the data, almost all of the increase in coverage of interventions in Area A was achieved after two years as well. When high coverage levels are already attained at the time of the MTE, of course, further substantial improvements in coverage are simply not possible because of a ceiling effect. However, it is important to note that coverage levels were maintained in Area A after achieving a high coverage level. World Relief has shown in their first Care Group project in Gaza Province that Care Groups continued to remain active and levels of coverage of key activities remained undiminished for four years after withdrawal of formal project activities (Pieter Ernst, personal communication).

The Care Group model is effective because it is a simple and straightforward way of engaging local people in their health problems, relying on peer-to-peer education among women, ensuring that every household is engaged, and empowering women and community leaders to improve their health in such a rapid and effective way that the improvements are apparent to everyone.

The Quality of the Project Leadership and the Team

The leadership team for the project includes the technical backstop team in the US (Carolyn Wetzel and Tom Davis) and the Child Survival Project Manager (Emma Hernandez). They are extraordinary in terms of their technical competence, experience, commitment to the achievement of project objectives, leadership, energy, and their ability to work with others. It is inspiring to see what can be achieved in an area of great need with the right leadership team, the

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[16] A full description of the Care Group model as developed by World Relief has been written: Laughlin, M. and World Relief Health Team (2004). The Care Group Difference: A Guide to Mobilizing Community-Based Volunteer Health Educators. Baltimore, MD, World Relief. It is available at http://www.coregroup.org/storage/documents/Diffusion%20of%20Innovation/Care_Manual.pdf.

[17] For a complete listing, go to http://www.caregroupinfo.org/blog/implementors.

[18] Edward A., Ernst P., Taylor C., Becker S., Mazive E., Perry H. 2007. Examining the evidence of under-five mortality reduction in a community-based program in Gaza, Mozambique. *Transactions of the Royal Society of Tropical Medicine and Hygiene* 101:814-22.

[19] UNICEF, 2008 (*Tracking Progress in Maternal, Newborn and Child Survival*. New York, UNICEF). This is available at: http://www.countdown2015mnch.org/reports-publications/2008report.

right set of interventions, an effective implementation methodology, and sufficient funds to get the job done. But without top-notch leadership, it is very difficult to get all the other pieces to fit together for optimal outcomes.

Empowerment and Building Partnerships with Communities

The enthusiasm of local women and community leaders for the project and its work was palpable in our field visits during the final evaluation. Everyone seemed to recognize that the purpose of this project, unlike the others they had been exposed to, was not give them handouts but to empower them to improve their own health with resources readily available to them – knowledge and skills provided by the project initially but then passed from mother to mother, locally nutritious foods, and the existing MOH facility-based health services. (This theme is explored more fully in the discussion of the qualitative findings and in Appendix 13.)

Other Contributing Elements

Other elements also made important contributions to the project's success, but space limitations prevent a full discussion of them. Among these is the overall framework for the project established by the USAID Child Survival and Health Grants Program as well as the managerial and technical support provided by Food for the Hungry headquarters staff. Also of critical importance were the well-designed and simplified educational messages and the pedagogical, behavioral-theory informed process for teaching these messages to the staff and to the mothers in the community. The initial process for establishing cooperation with the MOH and with the community leaders was critical as well. All of these elements – when combined with the Care Group model, a high-quality project staff, community partnerships, and empowered people – enabled the outstanding results identified by the Final Evaluation Team to be achieved by this project.

The Influence of the Local Context on the Relationship between Activities and Outcomes

In one sense, the firmly entrenched traditional beliefs regarding causes and treatments of life-threatening conditions – together with high levels of illiteracy – made it more difficult to promote health behaviors and practices. On the other hand, the people in the project area seem to be ready to accept the possibility that their long-held traditional beliefs are no longer appropriate for the world in which they now find themselves.

The dispersion of the population and the lack of transportation is a particular challenge, both for the project staff and for the people themselves. Obtaining transport to convey seriously ill patient to health facilities is a major challenge. The project was able to provide motorbikes for its Supervisors and bicycles for its Promoters and C-IMCI-trained Leader Mothers.

Current national estimates are that 12.5% of adults aged 15-49 years of age are HIV positive[20] and that the prevalence is much higher in Sofala province, where it is 26.5%.[21] The higher prevalence is attributed to the fact that Sofala hosts transport corridors from the port of Beira to neighboring countries. HIV/AIDS is the leading cause of death nationally, accounting for 27% of all deaths and 13% of under-five mortality.[22] It is unfortunate that the project did not

[20] http://www.unaids.org/en/CountryResponses/Countries/mozambique.asp (accessed 4 August 2010).
[21] http://www.unicef.org/mozambique/hiv_aids_2045.html (accessed 4 August 2010).
[22] Instituto Nacional de Estatística (Moçambique), Ministério da Saúde (Moçambique), MEASURE DHS+/ORC Macro. MOÇAMBIQUE: Inquérito Demográfico e de Saúde 2003. Maputo, Moçambique: Instituto Nacional de Estatística and Ministério da Saúde; 2005.

have the resources to engage the Care Groups in addressing the problems of HIV/AIDS (and associated tuberculosis) and reduction of mother-to-child transmission of HIV/AIDS directly, but with the increased utilization of prenatal care services as a result of promotion of these services by the project, and other FH HIV prevention programs active in the same areas, we can presume that more mothers are now being tested for HIV and obtaining appropriate treatment to prevent transmission to their babies. Continuing the project with an expansion into HIV/AIDS and tuberculosis would be a logical next step if funding were available.

Role of Key Partners in Helping or Hindering the Project to Achieve the Results It Did

The MOH was the key partner in this project. It certainly played an important enabling role in supporting the project in its activities. The MOH has established a good program of health care services at its Health Centers in the project area. The Final Evaluation Team never heard a single complaint from community members or from the project staff about MOH health facilities lacking medicines, patients being treated rudely, or the quality of care.. This is a remarkable achievement, and it certainly contributed to the success of the project since promoting the use of health facilities for life-threatening conditions was one of the important activities of the project at the community level.

Having said that, it is nonetheless unfortunate that the MOH could not be a more active participant in district-level project activities. MOH staff members were rarely available to participate in project activities (unless they received a per diem fee that the project did not have the funds to pay). Furthermore, a high turnover of MOH staff in all districts made it difficult to build personal relationships. At the provincial level, MOH staff received per diem to attend trainings and, in the case of the C-IMCI training, serve as lead trainers.

Overall Design Factors that Influenced Results

As previously mentioned, the Care Group model is the most important design feature that led to the project's achievements. However, other design factors are of critical importance as well, and these are inherent in the Care Group model: getting supervisors out into the communities, developing a strong community-based health information system, creating well-crafted educational messages, and giving an overarching priority to nutrition.

The project recognized the absolute necessity for the supervisory staff to spend time in the communities, meeting with community people, Care Group Volunteers, Care Groups, and community leaders in order to find out what the problems are and to look for ways to solve them. A rough estimate is that the Beira-based project leadership team spent 25% of its time in the project area and the Supervisors, 67%. The Promoters were already living in the project area where they worked, so they were, of course, working in the communities all of the time except for district meetings and quarterly training sessions in Beira.

Without the Supervisors and Promoters devoting most of their time to being in the field, it is hard to imagine that the project would have been as successful. One reason for this is that we heard of many situations in which a difficult moment was reached in the community in moving the project forward, and this led to project staff and Care Group Volunteers going to community leaders and asking them for their support. Invariably, the community leaders provided their support, making it possible for project activities to move forward.

The second critical design issue is the community-based health information system (C-HIS). Part of this was the capacity of the Promoters to interview mothers in randomly selected households – for the baseline and endline KPC surveys but also for the mini-KPCs. Then, through the process of home visitation carried out by Care Group Volunteers, births, deaths, and

Care Group attendance were reported at the time of Care Group meetings.[23] Finally, the project expanded this C-HIS to include interviews (verbal autopsies) by Promoters of families in which a death occurred to determine the cause of death. The presentation of this information to the staff and to the communities had a powerful reinforcing effect to help the project continue to progress in achieving its objectives.

The third critical design issue was the educational messages themselves. These are superb, finely tuned, and based on extensive experience and field testing. By promoting a process of local Care Groups turning these messages into their own songs further deepens the effectiveness of the message – it becomes their own message. The flipchart drawings and educational techniques are also models that are being adopted by other organizations (such as the Clinton Foundation in Mozambique and the National HIV/AIDS Strategy) because of their quality.

Finally, the project has given nutrition the central role it should have in improving the health of children. Well-nourished children are less likely to develop infections and they have a lower risk of death, [24] so improving nutrition in high-mortality, low-resource settings is a fundamental low-cost strategy, which this project has so well implemented – including helping mothers to understand that there are highly nutritious foods available locally for their children – including their own breast milk.

Implication of Findings

Progress toward Sustained Outcomes

What is the potential for the achievements of the project to continue now that the project has ended and funding has stopped? The new knowledge acquired by local people in the project area and their changed attitudes and behaviors will persist for at least some time into the future. One of the strengths of projects using the Care Group model is that a previous assessment in Mozambique, as we mentioned earlier, demonstrated that the Care Group members continue their work in visiting households and supporting mothers for at least four years after the formal project ended. Care Group projects have created new community norms, particularly for cleanliness, personal and environmental hygiene, prevention and treatment of childhood malnutrition, and prevention and treatment of common serious childhood illnesses. Given the similar approach, we can expect the same for this project. All community members who spoke about this issue in our focus group discussions at the time of the Final Evaluation confirmed that they expected the same.

The following quotes, which the Final Evaluation Team heard from people in the community, speak for themselves. One mother said:

> "We now know to wash our hands and use drying racks for our dishes. We know the importance of latrines and the need to clean up after a child has defecated. We have fewer child illnesses and fewer child deaths."

A Care Group Volunteer said:

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[23] Routine visiting of all homes is a fundamental part of a broader process for health improvement in defined populations which some refer to as the census-based, impact-oriented approach, described elsewhere (Perry H., Robison N., Chavez D., Taja O., Hilari C., Shanklin D., and Wyon J. 1999. Attaining Health for All through community partnerships: Principles of the census-based, impact-oriented approach developed in Bolivia, South America. *Social Science and Medicine* 48:1053-1067).

[24] Caulfield LE, de Onis M, Blossner M, Black RE. Undernutrition as an underlying cause of child deaths associated with diarrhea, pneumonia, malaria, and measles. Am J Clin Nutr2004 Jul;80(1):193-8.

"Our children are growing better now and there are fewer child deaths. We now know to have fewer children. Before, we were having children every year. We are very satisfied with our work. Before, other projects would give us things. But with this project we have learned a lot of things. Our beneficiary mothers, our husbands, and the community all respect us now. Our husbands are also happy because our houses are cleaner and because we know when to go to the hospital. We are very happy."

Another Care Group Volunteer said:

"Before, when our children became swollen [from kwashiorkor], we took them to the *curandero* (traditional healer), but now we know they need to go to the health center. We also know that if our own feet swell when we are pregnant we need to go to the health center. "

And one Village Leader told us:

"We like the project because it has brought many changes to our community. Our children are better nourished, and the mothers know how to give nutritional foods to malnourished children. We're now taking our children to the health center when they get sick."

Contribution to Replication or Scale Up

This project is a replication of Food for the Hungry's earlier Title II project in Sofala province. Thus, the success achieved by the Expanded Impact Project is a further verification of the validity and robustness of the methods and principles used by the project, including the Care Group model. The findings from this project should reinforce the already ongoing trend to apply this approach in other settings, not only among Food for the Hungry's programs but also among those of other organizations. The beneficiaries in a population of 1.2 million people reached by this project is twice as large as that reached by the earlier Title II project, so there is no doubt that this project represents a scale up of earlier efforts. Nonetheless, the need now is to replicate and scale up the project to even larger populations. Food for the Hungry has now expanded its use of Care Groups to its programs in Cabo Delgado in northern Mozambique using USAID Food Security funding. The experience with this project is informing developing programs of Food for the Hungry in other countries, and Ms. Wetzel and Mr. Davis are active in sharing the success of the Care Group model and encouraging its adoption by other organizations.

Attention to Equity

The very fact that the Care Group model ensures that every household in the project population is reached with basic education ensures that at least some degree of equity is achieved, even if it is not optimal. Of course, the full meaning of equity involves giving more attention and resources to those in greatest need, not simply ensuring equal attention and resources for everyone. Growth monitoring makes it possible to provide special attention to malnourished children and another way of addressing equity issues. Thus, using a modified Hearth approach to rehabilitate malnourished children is one of the important mechanisms of the project for achieving equity since it involves a special program of nutrition education and support for mothers and caretakers of malnourished children.

Role of Community Health Workers

The Promoters are community-level paid workers whose role was to teach health messages to the Care Group Volunteers in Care Groups and support them in their work at the household level. The project paid the Promoters a relatively generous salary (considering that they were living in isolated villages prior to their employment) of about $200 per month. If, by the term "worker," we mean paid health personnel, then Promoters are Community Health

Workers who were essential to the project's success. And, of course, the Care Group Volunteers, who worked approximately 4-8 hours a week and who received no monetary remuneration, were also essential to the project's success. Without Community Health Workers, the project could not have achieved what it did. Since the Promoters live in the village they worked in, they are a sustainable resource. Based on the findings of the operations research study of Care Group volunteers carried out in May 2010, it is possible to estimate the amount of volunteer time contributed for project activities: 80.0% of the total project effort was provided by the Leader Mothers (Care Group volunteers), 17.3% by the paid Promoters, 2.7% by the Mozambique-based management team, and 0.3% by the US-based technical support staff.

Contribution to Global Learning

The lessons from this project have major relevance for global efforts to improve the health of children around the world. At present, only 19 of the 68 countries in which 97% of the deaths of under-5 children are occurring are on track to achieve the Millennium Development Goal for children (MDG 4) by the year 2015. Only two of the 16 countries on track are in sub-Saharan Africa – Eritrea and Malawi.[25] As far as we know, there is only one sub-national area of sub-Saharan Africa that has documented achievement of MDG 4, and that is the Navrongo field research area in northern Ghana.[26]

Conclusions and Recommendations

The Food for the Hungry/Mozambique Child Survival Project is perhaps one of the world's best examples so far of what can be achieved at low cost to improve the health of children in high-mortality, low-resource settings. Dramatic improvements in coverage of key child survival interventions have been achieved quickly, and there is considerable direct and indirect evidence that a major decline in under-5 mortality has occurred as well. The methods and procedures used by the project are widely applicable in other high-mortality, low-resource settings, and the achievements appear to be sustainable. The effectiveness of the approach needs to be tested further in urban settings since most of the experience so far has been in rural settings. Specific operational recommendations for future child survival programming include the following:

For further replications of the Care Group model and its associated methods and procedures, the following modifications seem appropriate based on the findings of the Final Evaluation:

1. Registration of child and maternal deaths and births should be the first activity that Care Groups and Care Group Volunteers undertake, and it should continue throughout the life of the project. Verbal autopsies of selected child deaths (e.g., those in sentinel communities) identified through vital events registration should be a standard project activity, including regular discussion of the findings with project staff.

[25]World Health Organization, UNICEF. Countdown to 2010 Decade Report (2000-2010) with Country Profiles: Taking Stock of Maternal, Newborn and Child Survival. Geneva: World Health Organization and UNICEF; 2010.

[26] Binka et al., 2007 (FN Binka, AA Bawah, JF Phillips, A Hodgson, M Adjuik & B Macleod. Rapid achievement of the child survival millennium development goal: evidence from the Navrongo experiment in Northern Ghana. *Trop Med Int Health*, 12, 578-83).

2. The project should assist each community to maintain ongoing records of its monthly and yearly C-HIS information (which will make it possible to visualize longer-term trends) and also to share the progress of the project as a whole with the community.
3. Provide additional formal training to Promoters to enable them to become *Agentes Polivalente Elementares* (the emerging national-level CHW being developed by the MOH), which will strengthen the link of project activities to the MOH as will promoting formal meetings between the Mobile Brigades (outreach teams that provide immunizations, vitamin A, family planning services, and health promotion at the time of monthly community visits) with Care Group Volunteers (Leader Mothers).

The project's achievements need to be shared with the global health community, and its mortality impact needs to be assessed independently through direct retrospective demographic methods involving birth histories from a representative sample of women in the project population.

More importantly, Mozambique, the global health community, and USAID should consider the project's leadership and staff as a key resource for leadership in helping other parts of Africa – both within Mozambique and beyond – to implement similar programs elsewhere. This means providing additional financial support for current project activities that would make it possible to maintain the project's current achievements and enable the project's leadership and staff to provide training to others from outside the geographic area to learn the project's methods and procedures and adapt them to other contexts. Given the epidemiological importance of HIV/AIDS and tuberculosis in the project area, funding should also be obtained to enable the inclusion of community-based activities for the control of these priority conditions as well.

Because of the promising findings obtained here and elsewhere with the Care Group approach and related activities, the methods and procedures used for this project should be applied in larger populations with careful independent monitoring and mortality impact assessment. This recommendation is in harmony with a recommendation made arising from a comprehensive review of the effectiveness of community-based primary health care in improving child health, namely that "There is a need for rigorous assessments of community-based integrated approaches for improving child health at large scale."[27]

Finally, there is an urgent need to convey the potential of Care Groups more effectively to the global health community. The project staff members have already created a website[28] (in conjunction with World Relief) for diffusing this model and the lessons learned from use of Care Groups, and are leading a Care Group TAG in December 2010 (in association with USAID and MCHIP) as two steps in that process.

[27] H Perry, P Freeman, S Gupta, BH Rassekh. How Effective is Community-based Primary Health Care in Improving the Health of Children? Summary Findings and Report to the Expert Review Panel. Working Group on Community-based Primary Health Care, International Health Section, American Public Health Association, 2009 (available at http://aimdb.files.wordpress.com/2009/08/finalcbphcreporttoerp-7july2009.pdf).

[28] See www.CareGroupInfo.org

Annexes

Annex 1: Results Highlights: Rapid Expansion of Coverage

The Care Group methodology as implemented by Food for the Hungry in their Sofala Province project reached pregnant women and mothers of 0-23 month-old children in a population of 1.2 million people over a five-year period from October 2005 —December 2010 (including a no cost extension). Five Supervisors and 65 Promoters formed and trained 4,095 Care Group Volunteers (called Leader Mothers) who each were responsible for 12 other women who were either pregnant or who had child aged less than two years (Figure 1.1). One of the highlights of this project is the rapid expansion of coverage of key child survival interventions in a large population of beneficiaries. For instance, during the first two years of project activities, when the project began its activities in one-half of the project area (called Area A), coverage for all interventions expanded rapidly. Similar rapid expansion of coverage of key child survival interventions also occurred in the other half of the project area (Area B), some of which are shown in Table 1.1. For the nutritional interventions shown here, coverage increased on average by 44 percentage points in only two years. This is quite extraordinary, particularly for difficult to change customary behaviors such as those related to infant feeding. Others projects using the Care Group methodology have also achieved similar dramatic results.

There are several explanations for this remarkable phenomenon. First of all, the cascading effect of teaching means that during the same two-week period, all mothers in the project area are being taught the same health promotion message, so that there is almost a "shock and awe" phenomenon at work (and establishment of supportive social norms). Secondly, the women who are teaching the message are trusted neighbors (often chosen by the women that they serve) who are also practicing the message themselves as they are teaching it. This provides a powerful motivation to mothers who are learning a new way of caring for their children from a trusted neighbor who has learned a way to improve the health of her child from someone who has received this information from a trusted source.

The Care Group approach to behavior change for improving child survival has gradually expanded to larger and larger populations. The time has come to try this in larger populations to determine if similar rapid expansions in coverage can be achieved. If so, this methodology could play an important role in expanding behavioral interventions in high-mortality, low-resource settings, which are lagging behind coverage compared to services provided by outreach teams such as immunizations and vitamin A distribution.

Table 1.1. Rapid Expansion of Population Coverage

Indicator	Area	Baseline Coverage	After two years of implementation
Prevalence of exclusive breastfeeding for children 0-5m	Area A	17%	95%
	Area B	62%	87%
Provision of at least 3 meals (or snacks) each day for children 9-23m	Area A	33%	67%
	Area B	46%	66%
Provision of nutrient-dense foods for children 6-23m	Area A	29%	95%
	Area B	57%	91%

Increased feeding of children with diarrhea	Area A	31%	70%
	Area B	14%	71%
Averages		**36%**	**80%**
Average Increase	**44 points (122%)**		

Figure 1.1. Care Group Volunteer Teaching Mothers

Annex 2: Changes to the Project since Completion of the DIP

According to the Detailed Implementation Plan (DIP), the project was to work in a total of 10 districts. After the project started, the MOH requested that the project not work in two of these districts because another NGO was working there (Comussanas). In addition, the project decided to not work in Marromeo District because of political difficulties encountered in implementing the project there.

After a review of vital events collected by the Leader Mothers, the project noted how significant neonatal deaths were. A special module for training in the detection of danger signs among newborns and special counseling for mothers of newborns. A protocol was then established whereby Leader Mothers visited newborns every day during the first week of life, four days during the second week, three days during the third week, and once during the fourth week.

The project staff found more people than they expected based on government census information in the remaining districts, so it reached 11% more people than originally planned in the remaining seven districts.

There were no other changes made in the DIP.

Annex 3: Program Goals, Objectives and Indicators

The project had the following goals and objectives:

- Significantly reduce morbidity and mortality – especially among children 0-23 months of age and pregnant women
- Increase access to community and household IMCI-trained health providers in the program areas
- Transfer the knowledge, skills, tools, and passion needed for effective and sustainable community health development through the Care Group model to project partners – including Leader Mothers – in order to continue child survival activities once this project has ended

The project overall objectives were as follows:

- Improve child nutritional status
- Assure appropriate diarrhea case management
- Increase proportion of mothers of young children who have access to an IMCI-trained provider within one hour of their home
- Assure the sustainability, quality and expansion of the Care Group Model in Mozambique

Table 3.1. Specific Project Objectives and Their Indicators

SPECIFIC OBJECTIVE	INDICATOR
To decrease malnutrition (underweight) in children 0-23m	Percentage of children age 0–23 months who are underweight (WAZ<-2.0)
To increase exclusive breastfeeding of children 0-5m	Percentage of infants aged 0-3 months [per MOH norms] who were fed breast milk only in the last 24 hours
To increase feeding frequency of children 9-23m who are fed solid or semi-solids food at least three times a day	Percentage of children 9-23m who receive food other than breast milk at least three times per day [Nationally accepted indicator (Title II)]
To increase the proportion of young children fed nutrient-dense foods	Percentage of children 6-23 months of age with oil added to their weaning food [Nationally accepted indicator]
To decrease VAD by increasing the proportion of young children who regularly consume vitamin A rich foods.	Percentage of children 6-23m who have consumed at least one vitamin A rich food in the previous day
To decrease VAD by increasing the proportion of young children in Sofala who are regularly receiving vitamin A supplements	Percentage of children 12-23 months of age who have received one vitamin A capsule in the past six months
To decrease helminthiasis and improve nutritional status by increasing the % of young children who are regularly de-wormed	Percentage of children 12-23 months who received de-worming medication in the last six months
To increase the proportion of children 0-23m of age who participate regularly in growth monitoring/promotion activities	Percentage of children aged 0-23 months who were weighed in the last four months (card-confirmed)
To increase the proportion of young children with diarrhea who are given ORT in order to decrease dehydration and death	Percentage of children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids (RHF)
To increase feeding of young children during diarrhea	Percent of children aged 0-23 months with diarrhea in the last two weeks who were offered the same amount or more food during the illness
To increase the proportion of mothers of young children who are competent in preparation of ORS	Percentage of mothers of children 0-23m who can correctly prepare ORS
To increase the proportion of mothers of young children who know when to seek care for sick children	Percentage of mothers of children age 0–23 months who know at least three signs of childhood illness that indicate the need for treatment
Continue to expand usage and improve the Care Group model in Mozambique	The MOH in at least one other Mozambican province requests assistance (during the life of the program) from FH to expand the Care Group model into their geographical area. OR is conducted on the reasons for Care Group effectiveness.
To increase to 80% the proportion of LMs trained in IMCI who can properly use the IMCI protocols for children 2-59m of age	% of Leader Mothers trained in community-IMCI modules who score 80% or higher on an IMCI QI checklist.
To increase to 80% the proportion of LMs who are able to do high-quality health promotion	% of Leader Mothers who score 80% or higher on the Health Promotion checklist (QIVC).
Increase the capacity of local partners and 90% of project communities to effectively address local health needs.	% of first-phase Care Groups that continue to meet and do health promotion following reduction of health Promoter staff in Year 2.5.

Annex 4: List of Publications and Presentations Related to the Project

The project has given several presentations in Mozambique, including one in Maputo for USAID and NGOs, one in Beira at the Catholic University there, one for other NGOs working in Beira, and one for the MOH Provincial Office in Beira. In addition, the project gave four separate presentations about its work to community leaders in the project area.

The educational materials developed by the project have been adopted by the Clinton Foundation in Mozambique and by CCS (Centro Cooperazione Sviluppo de Italy), which is working in Mozambique as well. The project has published a book of recipes to promote good child nutrition (in conjunction with CUAMM – Doctors with Africa) and the MOH). Educational materials for zinc are in preparation at present. A website with information, methods, tools, and online narrated presentations related to Care Groups was created, as well (in collaboration with World Relief): www.CareGroupInfo.org.

Food for the Hungry staff members have given a remarkable number of presentations in the US and in other countries about its work. These include:

1. May 2006: Breaking Down Barriers to Behavioral Change: Barrier Analysis was presented at a USAID brown-bag meeting in Washington, DC by FH CS HQ staff
2. Lauren Erickson-Mamane, FH's child survival backstop up to July 2007, presented at the June 2007 Mini-University on *Using Formative Research to Inform Program Design: Barrier Analysis.*
3. Health Behavior Health Education Global Health Roundtable at the UNC-Chapel Hill in October 2007: Mr. Davis presented on the Barrier Analysis tool for graduate students in this group featuring FH's work in child survival.
4. 2007 Christian Connections for International Health conference: Mr. David presented on Child Survival advocacy. During this session, participants learned easy-to-use tools to change policy that affects the people that they are called to serve (e.g. mothers and children). The workshop focused on equipping participants with tools, using exercises to practice using these tools, and advocacy action ideas to take home with them to generate action in their communities and the world.
5. CORE Spring and Fall meetings in 2007: In the Spring meeting, Mr. Davis presented on Barrier Analysis results on AIDS prevention in four countries. He also presented the opening and closing sessions on child survival as Chairman of the Board of the CORE Group, including a discussion of the "last mile" problem and how PVOs have taken the lead in solving this problem.
6. International Food Aid Conference in Kansas City, April 2007: Our presentation included information on mortality declines using FH's Care Group model (which is currently part of our child survival project in Mozambique).
7. January 2007 Food for the Hungry Launch conference in the Dominican Republic: We featured FH's USAID-sponsored child survival and Title II health work.
8. 2007 APHA Conference, session entitled, "*Care Groups significantly reduce child mortality in Mozambique*" as part of the preformed panel session, "*Community-based Approaches Are Essential in Global Fight to Increase Child Survival*" and is scheduled for Monday, November 05, 2007: 8:30 AM-10:00 AM in Room 158A.

9. 8. June 2007: Barrier Analysis as a tool to improve health messaging and improve behavior change was shared at the CSHGP Mini-University by FH CS HQ staff.
10. April 2007: Community Transformation in Bolivia & Mozambique through a Behavior-change Focus presented at the International Food Aid Conference by FH CS HQ staff.
11. July 2008: Community Health Programming with Impact: The Care Group Model and its Role in Mortality Reduction in Mozambique was presented to the USAID mission in Mozambique and other CS stakeholders in Maputo, Mozambique by FH CS HQ staff.
12. June 2008: Barrier Analysis methodology, the results of the exclusive breast-feeding Barrier Analysis study, how results were used to create project messages, and the impact and affect this had in program areas was presented at the Global Health Council by FH CS HQ staff.
13. January 2008: Community Health Programming with Impact: The Care Group Model and its Role in Mortality Reduction in Mozambique was presented to USAID and other CS stakeholders in Washington, DC by FH CS HQ staff.
14. April 2008: Experience gained from CS project design, survey implementation, and establishing monitoring and evaluation systems was presented to YWAM community health students at the University of the Nations by FH CS HQ staff.
15. November 2007: Care Groups significantly reduce child mortality in Mozambique was presented at the APHA annual meeting by FH CS HQ staff.
16. October 2007, Barrier Analysis: A Tool for Successful Behavior Change Interventions in International Health Programs presented at UNC-Chapel Hill School of Public Health's Health Behavior/Health Education Global Health Roundtable by FH CS HQ staff.
17. Presentation by Tom Davis on "**Behavior Change Strategies for the Postnatal Period: What works**" at the Newborn Care Data Analysis and Program Review Workshop to Guide Program Scale Up (April 30 – May 1, 2009, hosted by JHU and Boston University)
18. Panel Presentation by Tom Davis, presented by Carolyn Wetzel at the Global Health Council (Nov 2009), titled: Community Discovery of Determinants of Exclusive Breastfeeding (Mozambique). Presentation given to ~100 GHC attendees. The presentation explained how the CS project used BA to increase EBF and reduce malnutrition.
19. Plenary Presentation by Carolyn Wetzel at the CORE Spring Meeting (April 2009), titled: Role of Formative Research in the Promotion of Exclusive Breastfeeding. The presentation was given to ~150 NGO, Consultants, and USG employees and accomplished the objectives of: Explain the three types of formative research used to develop program messages and guide beneficiary targeting (Barrier Analysis, Local Determinants of Malnutrition Study, and Focus Groups) and Explain how messages were incorporated into the behavior change methodology
20. Presentation to USAID Maputo consultants present in Mozambique to elaborate the new C-IMCI/CHW strategy (Feb 2009) by Emma Hernandez, titled: Achieving Equity, Coverage, and Impact through a Care Group Network Sofala Province, Mozambique. The presentation was given to ~50 representative of NGOs, the United Nations, Government of Mozambique and the Government of the US.
21. District level Community Leader Meetings were held by 2 teams of CS Staff (Team 1: Emma Hernandez & Cecilia Lopez, Team 2: Luciano Menete and Jose Manuel) in each

CS district from July 15-17, 2009. Approximately 300 people attended the 7 meetings. CS Program objectives, indicators, and achieved results were shared.

22. Presentation by Emma Hernandez during a MOH biannual meeting to representatives of the MOH, NGO's, and the United Nations working in the health arena about the mortality tracking methods and results in the CS project. August 2009.
23. Presentation by Tom Davis and Carolyn Wetzel to ~ 18 USAID DRC Mission Representatives and MOH representatives (Jan 2009) about the effectiveness of Care Groups in reducing malnutrition.
24. Presentation by Carolyn Wetzel to the Health Ministry Team of Food for the Hungry (November 2008) titled: Mini-KPC Methodology. This presentation was given to ~6 of Food for the Hungry's Health Program Managers via Elluminate.
25. Presentation on FH/Mozambique Handwashing with Soap results to the Public Private Partnership for Handwashing (December 2008 at AED HQ)
26. Online presentation to the CORE Community on FH/Mozambique's Care Group model and handwashing with soap results on Jan 13, 2008 (in collaboration with WR)
27. Presentation on FH's results in hand washing with soap ("Why #2 is #1") at the 2009 CORE Group Spring Meeting.
28. How You Can Be a Healthcare Hero presentation at FH's Summit Conference in Phoenix Arizona: Discussion of how church mission groups can do health promotion on child survival behaviors in Spring 2009.
29. Presentation by Tom Davis to Mozambique USAID Mission, MOH, INS, and stakeholders from NGO's operating in Mozambique on the Results of the Care Group Operational Research in May 2010 in Maputo.
30. Presentation by Tom Davis to District Level MOH, INS, and stakeholders from NGO's operating in Mozambique on the Results of the Care Group Operational Research in May 2010 in Beira.
31. Presentation by Tom Davis, Emma Hernandez, and Carolyn Wetzel to the Christian Groes-Green, a Consultant for USAID from the University of Copenhagen/ Columbia University regarding the impact of Care Groups and inclusion of the methodology in the National Plan for Food Security in May 2010 in Maputo.
32. Presentation by Carolyn Wetzel to FH Country Directors, Program Directors, and Key Management personnel at the FH Corporate Conference in Rayong, Thailand about Barrier Analysis and Impact of Care Groups.
33. Presentation about on the Care Group Criteria by Carolyn Wetzel and Tom Davis at the 2010 CORE Spring meeting in Baltimore, Maryland.
34. Presentation on Using Social Network Analysis to Save Children's Lives by Tom Davis at the 2010 Sight for Life Conference at Yale University.
35. Presentation on the Care Group methodology to USAID consultants designing the Mozambique national community health worker strategy by Emma Hernandez in October of 2009.

Annex 5: Project Management Evaluation

The following report represents a self-assessment by the Beira Senior Leadership Team for the project which was led by Dr. Perry.

Planning

Because of the great geographic area of the project and the size of the population served, we should have had a little more money. We often had to start another activity at the same time we were doing another. From time to time we were quite rushed. But, all and all the project was well-designed, including the field activities. We had our five-year plan, an annual plan, a three-month plan, and a one-month plan. Usually we were running just a little behind schedule, but not far behind. When the second phase of the project started, the workload increase dramatically and we were very busy.

What became problematic was when a new activity was requested of us that we had not been anticipating and had not planned for. One is that the Project Director has to serve on a rotating basis as Director of the FH/Beira office, and this took time away from her project duties. Another example was the operations research.

Supervision of Project Staff

Overall, we had a good supervisory structure. However, we think that we should not put a Supervisor (*Oficial*) in charge of more than one district. (We had two Supervisors who each were responsible for two districts.) Generally, the management was in charge of the situation of all the staff. However, the distances involved created challenges. Sometimes the Beira staff could not get to the field because they were tied up with work in the office.

The supervisory checklists were quite helpful – not only for the person being supervised, but also to have an idea of the quality of supervision that the supervisor is providing. (The Supervisors have a checklist to use when they supervise a Promoter, and the Promoters have a checklist to use when they supervise a Leader Mother.) For example, if there is no supervisory checklist filled out, then the supervision probably didn't take place. Or, one supervisor fills out three checklists in exactly the same way for the same date, this leads to suspicion.

Human Resources and Staff Management

The project has done a good job selecting staff. The job qualifications are well-thought- out. We were fortunate to be able to hire persons who had experience. Some of these were from the FH Title II project. We should have had more Supervisors and Promoters. We had an adequate number of staff in the Beira office.

When we had a problem, we sat together and solved it. We have had a good team with good morale. We always felt like we were a team working together. Having very clear job descriptions that everyone knew helped us to know what our roles were.

We normally met once a week as a staff in Beira, but sometimes it was more and sometimes it was less. We made good use of our meeting time and kept the length to a minimum. Normally, they lasted 1-3 hours. We had an agenda ready before the meeting.

Compared to the other FH projects that are based in our office here in Beira, our project had better planning and better meetings. We have been better at prioritizing our work. We have developed momentum as a project team and we are constantly learning. The other projects seem to be in a "monotonous rut."

If one of our Beira team is not present, the others are empowered to pick up the work that needs to be done. We are interchangeable. Also, there is a will to do things with quality.

We had a fairly high turnover of Supervisors (*Oficiales*). One of the Supervisors died of AIDS and several were recruited by other NGOs for higher-paying jobs. Of the original 65 Promoters, 52 were still working with the project at the end. Several resigned to enter training to become teachers, and several died.

Financial Management

When we started, we had a huge project and had a very limited budget, so we knew we would have to economize with everything. We learned how to do our work simply but maintaining quality. We don't rent conference rooms for meetings, for instance, but use the space at our office. We don't pay to have invitations printed (for special events), but we make our own yet they are of very high quality. Sometimes we take public transport into the project area (instead of using a project vehicle) to save money.

Because of the long distances involved, we have had problems getting receipts back, so we have had to adjust our financial management to keep the work from stopping. We have been very strict with receipts, and we only use vendors that can certify that they are paying their government taxes. (We think this will help our country to develop.)

The project has built up a surplus and has asked for a three-month extension. This arose in part because of delayed financial reporting from the Beira office to the HQ office in the US.

Logistics

We purchased high-quality motorbikes, and we maintained an inventory of spare parts so that there would not be a delay in getting them repaired when they broke down.

Most of the time motorbikes were better than a vehicle. During the raining season, the motorbikes could reach 90% of the communities, and so could the Land Rover. But the Ford pickup could only reach about 50% of the communities. Even in the dry season the motorbikes are better because in places there are no roads, and one can pass on a motorbike. The disadvantage of a motorbike is that one cannot take a second person, and sometimes we like to be able to take MOH staff to the communities.

We had a good plan for purchasing well in advance all of the supplies that we would need so that we wouldn't have to buy the at the last minute at a higher price. There were not significant stock outs of supplies during the project. The mebendazole that we use for de-worming was a donation from the US, and vitamin A was provided by the MOH.

We had a major problem with the zinc that the MOH purchased for us. USAID provided the MOH with funds for this. The zinc was delayed in arriving, and the expiry date was only in 6 months after arriving (contrary to MOH policies for purchasing drugs). However, this problem was beyond our control.

Information Management

We send a monthly report to the US, and we sent a quarterly report to USAID and the MOH. And, of course, we prepare an annual report for USAID. At the district level, we send a monthly report to the district MOH.

We have facilitated meetings between the MOH and community leaders to review project reports and discuss common problems. This has provided the MOH with important new insights regarding problems local people have in accessing MOH services.

The community-based health information system (C-HIS) has worked well. The mini-KPCs and the KPCs have been essential for us to know how well we are doing. The monthly reports of the Supervisors have been very helping us to know what is happening in the field. All of the various reports complemented the others (including the verbal autopsy reports).

At the outset, we had 20% of an M&E person working in the Beira office. This resulted in inadequate attention to the project. Hiring a fulltime M&E person led to a major improvement in the quality of the work.

Technical and Administrative Support

Tom Davis and Carolyn Wetzel provided top-notch technical assistance. There technical support was invaluable. We learned so much during the project – it was like being a university student again. Whenever we asked them a question (by internet), we received an answer promptly – almost always on the same day. But when they asked us for something, we found it hard to respond as quickly because we had so many other complications to deal with. Sometimes we felt that they had trouble understanding all of the other demands on us that slowed down our capacity to respond to their requests.

Sometimes we had a challenge coordinating our budget here in Mozambique with the budget in the US. For some reason they were not always the same.

Management Lessons Learned

<u>Planning</u>

We should have had only one Supervisor per district. We should have given the Promoters some flexibility in the number of Care Groups that they supported. Sometimes, for those who had long distances to traverse, they should have had a smaller number. (What actually happened was that every Promoter was responsible for five Care Groups regardless of distance traveled.)

We have learned the important of planning well with anticipation. We have learned to hold meetings only when they are necessary and use an agenda for the meeting. We have learned that cross-training (so that one person at the Beira office can do another's job) is useful.

We also learned that the initial salaries we gave Promoters were insufficient, and we raised them.

<u>Supervision</u>

We have good supervisory tools. They help us to know exactly what supervision is taking place. The way in which the supervisory form is completed helps us to have an idea of the quality of supervision.

It is important for staff members to know they are being supervised and that mechanisms are in place to determine if they are not doing a good job.

Human Resources and Staff Management

We have learned that motivate people do a better job than poorly motivated.

Other Issues Identified by the Team: None

Annex 6: Workplan Table

	Year 1		Year 2				Year 3				Year 4				Year 5			
Activity	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q3**	**Q1**	**Q2**	**Q3**	**Q4**
PHASE I DISTRICTS IN SOFALA																		
Elaboration of DIP	X																	
Orientation for Promoters	X																	
Finish forming the Care Groups	X																	
Revising and testing Care Group Module 1	X																	
CSP mgr in US	X																	
Supervision/CQI/Verbal Autopsy Training	X																	
Training of HPSOs, Promoters, MOH and partners on **Module 1 Care Group Orientation**	X																	
Phase I Promoters train LM on Module 1, LMs do health promotion on Module 1		X																
Revise and pre-test Module 2		X																
Community HH/IMIC TOT for HPSO and Promoters		X																
Community IMCI trained HPSO and Promoters begin Training Selected LMs in C-IMCI in each district		X																
Training of HPSOs, Promoters, MOH and partners on **Module 2 Sanitation and Hygiene**		X	X															
Phase I Promoters train LM on Module 2, LM do health promotion on Module 2			X															
Annual review meeting of Project Partners; Development of Year #2 Annual Implementation Plan & Use/ Analysis of Verbal Autopsies Workshop (FHI HQ Backstop visit)			X															

	Year 1		Year 2				Year 3				Year 4				Year 5			
Activity	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q3**	**Q1**	**Q2**	**Q3**	**Q4**
Revise and pre-test Module 3			X															
Mini KPC and anthropometry as well as KPC workshop and data analysis workshop				X														
Training of HPSOs, Promoters, MOH and partners on **Module 3**				X														
Phase I Promoters teach LMs on Module #3; LMs do health promotion on **Module #3**				X	X													
Revision and pretesting of Care Group **Module #4: Breastfeeding**			X	X														
Training of Phase I District Coordinators and Promoters in Care Group Module #4					X													
Phase I Promoters teach LMs on Module #4; LMs do health promotion on Module #4					X	X												
Revision and pretesting of Care Group **Module #5: introduction of Complementary Foods**					X													
Training of Phase I District Coordinators and Promoters in Care Group Module #5						X												
Phase I Promoters teach LMs on Module #5; LMs do health promotion on Module #5						X												
Revision and pretesting of Care Group **Module #6: Micronutrients**						X												
Training of Phase I District Coordinators and Promoters in Care Group Module #6						X												
Phase I Promoters teach LMs on Module #6; LMs do health promotion on Module #6							X											
Annual review meeting of Project Partners & Development of Year #3 Annual Implementation Plan (FHI HQ Backstop visit)							X											
Revision and pretesting of Care Group **Module #7: Nutrition and Care for**						X												

	Year 1		Year 2				Year 3				Year 4				Year 5			
Activity	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q3**	**Q1**	**Q2**	**Q3**	**Q4**
Pregnant Women																		
Mini-KPC & anthropometry for Year Two								X										
Training of Phase I District Coordinators and Promoters in Care Group Module #7								X										
Phase I Promoters teach LMs on Module #7; LMs do health promotion on Module #7								X										
Catch up on modules									X									
Mid-term evaluation									X									
PHASE II DISTRICTS IN SOFALA																		
KPC, FGDs, and Barrier Analysis studies.									X									
Selection of Phase II Promoters and formation of Community Development Committees									X									
Community mapping and census activity									X	X								
Identification of Leader Mothers and formation of Care Groups									X	X								
TOT for District Coordinators and Promoters on **Hearth Nutritional Rehabilitation Methodology**;									X									
TOT for other partners on **Hearth Nut. Rehab Methodology**									X									
Begin Hearth Methodology & PD studies in project communities									X									
Mini-KPC & anthropometry workshop (Phase II staff)										X								
Supervision/CQI/Verbal Autopsy Training										X								
Training of HPSOs, Promoters, MOH and partners on **Module 1 Care Group Orientation**										X								

	Year 1		Year 2				Year 3				Year 4				Year 5			
Activity	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q3**	**Q1**	**Q2**	**Q3**	**Q4**
Phase II Promoters train LM on Module 1, LMs do health promotion on Module 1										X								
Training of HPSOs, Promoters, MOH and partners on **Module 2 Sanitation and Hygiene**										X								
Phase II Promoters train LM on Module 2, LM do health promotion on Module 2											X							
Annual review meeting of Project Partners & Development of Years #4 & 5 Annual Implementation Plan (FHI HQ Backstop visit)											X							
Community HH/IMIC TOT for HPSO and Promoters											X							
Community IMCI trained HPSO and Promoters begin Training Selected LMs in C-IMCI in each district											X							
Mini KPC and anthropometry year 4												X						
Training of HPSOs, Promoters, MOH and partners on **Module 3 Diarrhea**												X						
Phase II Promoters teach LMs on Module #3; LMs do health promotion on **Module #3**												X	X					
Training of Phase I District Coordinators and Promoters in Care Group Module **#4 Breastfeeding**													X					
Phase II Promoters teach LMs on Module #4; LMs do health promotion on Module #4													X	X				
Training of Phase I District Coordinators and Promoters in Care Group Module **#5: introduction of Complementary Foods**														X				
Phase II Promoters teach LMs on Module #5; LMs do health promotion on Module #5														X				
Training of Phase I District Coordinators and Promoters in Care Group Module **#6 Micronutrients**														X				

	Year 1		Year 2				Year 3				Year 4				Year 5			
Activity	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q3**	**Q1**	**Q2**	**Q3**	**Q4**
Phase II Promoters teach LMs on Module #6; LMs do health promotion on Module #6															X			
FINAL KPC																X		
Final Evaluation																	X	X
Training of Phase I District Coordinators and Promoters in Care Group Module #7 **Nutrition and Care for Pregnant Women**																X		
Phase I Promoters teach LMs on Module #7; LMs do health promotion on Module #7																X	X	
Catch up on modules for Phase II																	X	
New module for Phase I and Phase II Promoters, LM and BM																	X	X
Lessons Learned Workshop for PVOs, NGOs, MOH, and other Stakeholders																		X
Hearth Screenings									X		X		X		X		X	
Barrier Analysis			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Coordination with Partner and MOH	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Monthly HPSO and Promoter Meetings	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CS coordination team quarterly meetings	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Annex 7: Rapid CATCH Table

Rapid CATCH Indicators		BL Value	MT Value	Final Value
1	Percentage of children age 0-<24m who were underweight (-2SD from the median weight-for-age, according to the 1978 WHO/NCHS reference population)			
2	Percentage of children age 0-<24m who were born at least 24 months after the previous surviving child			
3	Percentage of children age 0-<24m whose births were attended by skilled health personnel (Doctor or nurse)			
4	Percentage of mothers with children 0-<24m who reported receiving at least two tetanus toxoid injections before the birth of their youngest child			
5	Percentage of children 0-<6m who were exclusively breastfed during the past 24 hours, based on dietary recall			
6	Percentage of children 6-<10m who received breast milk and complementary foods during the last 24 hours, based on dietary recall			
7	Percentage of children age 12-<24m who are fully vaccinated before the first birthday			
8	Percentage of caretakers with children age 12-<24m who recalled that their child received a measles vaccine			
9	Percentage of children 0-<24m who slept under an ITN the previous night			
10	Percentage of caretakers with children 0-<24m who cited at least two known ways of reducing the risk of HIV infection			
11	Percentage of caregivers of children 0-<24m who report washing their hands with soap/ash at the four critical times			
12	Percentage of caretakers with children 0-<24m who know at least two childhood illness danger signs for seeking care immediately			
13	Percentage of children 0-<24m who were offered increased fluids and continued or increased feeding during illness			

** Denotes statistical significant (p<0.05)*

Annex 8: Evaluation Team Members and Their Titles

The Evaluation Team consisted of the following persons:

Henry Perry, MD, PhD, MPH Johns Hopkins University, Evaluation Team Leader
Emma Hernandez Avilan, BSN, Child Survival Program Manager, FH
Cecelia Lopes, Coordinator of Monitoring and Evaluation, FH
Luciano Menete, Field Coordinator, FH
Tom Davis, MPH, Senior Director of Program Quality Improvement, FH
Carolyn Wetzel, MPH &TM, Director of Health Programs, FH

Supervisors (Oficials)
Barroso Linda (Caia, Chemba and Marringue Districts)
Ginto Nunguiane (Gorongosa District)
Amelia Azevedo (Nhamatanda District)
Miranda Luis (Manga District)
Isaias Abilio (Dondo District)

Annex 9: Evaluation Assessment Methodology and Activities

The Final Evaluation took place in July 2010. A household knowledge, practice and coverage (KPC) survey had been carried out in June 2010 by the project staff. The data were entered into EPI INFO by the senior project staff members and analyzed by Tom Davis.

The Evaluation Team worked together to review the KPC findings and information available in the project's health information system (HIS). The Evaluation Team designed a set of questions for focus group discussions (FGDs) with community members and project staff members and for interviews with key individuals at the MOH. Communities selected for FGDs were selected at random.

Once all of this information had been gathered together and reviewed, the Evaluation Team discussed the findings and their implications.

The KPC report is shown separately in Annex X. Annex X lists the questions for the FGDs and the findings from the individual FGDs.

The schedule of evaluation activities was as follows:

June 7-18	Household interviews for KPC survey
9 July	Departure of Henry Perry and Tom Davis from the US
11 July	Arrival of Henry Perry and Tom Davis in Beira
12 July	Meeting with Project Staff to Discuss Project Structure and Function
13 July	Travel to Caia (8 hours)
14 July	Interviews in Caia and surrounding village
15 July	Interviews in Chemba and surrounding communities
16 July	Interviews in Gorongosa and surrounding communities
17 July	Interviews in Nhamatanda and surrounding communities
19 July	Interviews in Beira (Manga community) and writing up of findings
20 July	Write up of findings
21 July	Write up of findings and presentation to Provincial MOH and local NGO Organizations in Beira
22 July	Write up of findings and travel to Maputo
23-5 July	Write up of findings
26 July	Presentation of findings to MOH, UNICEF, World Food Program, and NGOs in Maputo[29]
27 July	Departure of Henry Perry and Tom Davis from Maputo
28 July	Arrival of Henry Perry and Tom Davis in the US
August 2010	Completion of Final Evaluation report

[29] USAID had been invited but because of staff shortages was unable to send a representative

Attendees at the Dissemination Seminar at the MOH Offices in Beira on 21 July 2010 included representatives from the following organizations:

Ministry of Health, Provincial Office for Sofala District
Health Alliance International
Catholic University

Attendees at the Dissemination Seminar at a private venue in Maputo on 26 July 2010 included representatives from the following organizations:

Ministry of Health
INE (National Institute of Statistics)
UNICEF
World Food Program
FANTA
Adventist Development Relief Agency
Family Health International
Health Alliance International
Save the Children
World Vision

Annex 10: Questions Asked during Field Visit

Ministry of Health

Please tell me everything that you know about the Care Groups that were set up in the communities near your health facility? How were they set up? Who attends them? Who goes to the Care Group to train people? What is the purpose of Care Groups?

1. How has the project helped you in the MOH to reach your own goals and objectives? What were the challenges that you encountered in working with the project?
2. What was the project trying to achieve? Do you believe that the project has met this goal?
3. What aspects of the project do you and others in the MOH value the most?
4. Have you seen any changes in attitudes or behaviors in the community that you think are attributable to the project?
5. Has the information collected by the project been helpful to you in your programs? If so, how?
6. Do you think that the Care Group work should be continued? If so, how might the MOH take over the Care Group work? What would the MOH need to do in order to accomplish this?

VILLAGE LEADERS

1. What information collected by the Care Groups do you find useful? How have you used this information to make changes in your community? Can you give any examples?
2. When was the last time that you met with the Food for the Hungry project leaders? How often have you met with them over the past several years? In what ways were these meetings helpful?
3. What is your desire for the health of this village in the future? How do you think the village can achieve this?
4. How have the Leader Mothers been helpful in the community?

SUPERVISORS (*OFICIALS*)

1. What is the most important health change you have seen in your districts as a result of the project?
2. How well did the project prepare you to do your work? What do you wish you had been taught that you were not taught?
3. How many times a month did your supervisor (*Coordinador*) meet with you? In what ways did your supervisor enable you to do your job? Do you think you would have been able to do this without a supervisor? Can you do it in the future without a supervisor?
4. What challenges did you encounter in performing your work?
5. Which of your current activities as an Official do you think you would want to or be able to continue in the future?
6. Did you feel supported in your role as an Official? By whom and in what ways?
7. How has your life or your thinking changed because of this project?

8. What were the most frustrating parts of your job? Why? What were the most rewarding parts of your job? Why?

PROMOTORS

1. What health change have you seen in your village as a result of the project?
2. How well did the project prepare you to do your work?
3. How many times a month did your supervisor (Official) meet with you? In what ways did your supervisor enable you to do your job? Do you think you would have been able to do this without a supervisor? Can you do it in the future without a supervisor? Did you find the use of quality check lists that you used and that the Official used to be helpful? Why or why not?
4. What are the main challenges that you encountered in performing your work?
5. Were there any health messages that were more difficult to understand? Were there any messages that were more difficult to teach? What are they and why?
6. Which health behaviors were more difficult for mothers to accept and adopt? Why?
7. Did you feel supported in your role as a Promoter? By whom and in what ways?
8. What were the most frustrating parts of your job? Why? What were the most rewarding parts of your job? Why?

LEADER MOTHERS

1. What change have you seen in your village as a result of the project?
2. How well did the project prepare you to do your work?
3. In what ways did your Promoter enable you to perform your responsibilities?
4. What challenges did you encounter in performing your work?
5. Which of your current activities as a Leader Mother do you think you would want to or plan to continue in the future? Why?
6. Were there any health messages that were more difficult to understand? Were there any messages that were more difficult to teach? What are they and why?
7. Which health behaviors were more difficult for mothers to accept and adopt? Why?
8. Did you feel supported in your role as a Leader Mother? By whom and in what ways?
9. Tell me a problem in performing your role as a Leader Mother that you've had in the last few months? What did you do to address it?
10. Did you have any challenges collecting information on births and deaths from your households? How easy will it be to continue to collect this information?
11. In the future, if you see a child who is not growing well what would you do to help?

MOTHERS

1. What health change have you seen in your village as a result of the project?
2. Do you feel that this project has had an effect on reducing the number of child deaths in the village?
3. Of the health behaviors you were taught, which were the most difficult to adopt? Why?
4. Have you seen any improvements in your child's health? If so, what were they?
5. In the future, if you see a child who is not growing well, what would you do to help?
6. Is there anything else that you would have liked the Leader Mother to teach you?
7. Do you believe that your Leader Mother will continue to visit you after the project ends?

Annex 11: List of Persons Interviewed and Field Activities Observed

Tuesday 13 July, the Project Evaluation Team traveled 8 hours to Caia. Then, beginning on Wednesday 14 July and continuing until Monday 19 July (with Sunday taken as a day of rest), the Evaluation Team spent three and one-half days in the communities, interviewing community members as shown in Table 10.1. Altogether, seven villages were visited from five of the seven districts which the project covered. In one of these districts (Chemba), the District Director of the Ministry of Health was also interviewed. He is the only current District Director in the project area that has been there throughout the entire five years of the project. The Evaluation Team split into two parts, with two to three members for the village-based interviews (so that a staff member speaking the local language could translate the local language into Portuguese and then from Portuguese to Spanish or English). Dr. Perry conducted the interviews with District MOH official. Interviews with the village leaders, Care Group Volunteers (Mother Leaders), and beneficiary mothers were carried out separately, usually with about 8-12 persons in attendance. Altogether, 17 focus group discussions were held, one MOH official was interviewed, and five Promoters were interviewed. Annex 21 contains photos taken during this field trip.

Table 11.1 Community Members, Project Volunteers and Staff, and MOH Officials Interviewed

Date	District	Village	Beneficiary Mothers	Leader Mothers (Care Group Volunteers)	Promoters	Village Leaders	MOH Officials
Wed., 14 July	Caia	District			√		
		Chipuazo	√	√		√	
Thurs., 15 July	Chemba	District					√
		Lambane (and surrounding villages)	√	√		√	
Fri., 16 July	Gorongosa	Jujenji	√	√		√	
		Balamansa	√	√		√	
Sat., 17 July	Nhamatanda	Vinho	√	√			
		Nhampoka	√	√			
Mon., 19 July	Beira	Manga		√			
Total number of focus group discussions conducted			6	7		4	

Project Activities Observed During Field Visits

A monthly staff meeting held in Caia District attended by the District Supervisor and five promoters.

Songs composed by local Care Groups about the educational lessons they had learned.

Nutritional educational sessions at which local nutritious foods are prepared by Beneficiary Mothers and Leader Mothers together.

Drama of a Promoter meeting with one of his Care Groups (asking one of the Leader Mothers to summarize the lesson from last month). He went over verbal autopsy findings with the Care Group. The group sang a song about prevention and treatment of diarrhea.

Drama of a Leader Mother with her Beneficiary Mothers and a malnourished child detected by MUAC.

Drama of a Leader Mother visiting her Beneficiary Mother who has just given birth.

Annex 12: Summary of Focus Group Discussions in the Project Site

14-17 July 2010

Most of the focus group discussions (FGDs) were held a central point in the community with a Promoter or a Supervisor translating the question into the local language (Sena or Ndau) and translating the response back into Portuguese, and then either Emma Hernandez (Project Director) or Cecelia Lopes (M&E Director) would translate into Spanish (both evaluators spoke Spanish). In addition, we interviewed five Promoters (in two separate groups) and interviewed the MOH Director of one district.

A summary of the themes has been placed in the main text of the report (Qualitative Evidence of Progress in Achievement of Project Objectives). What follows is a detailed report of the findings from the FGDs for each of the category of discussants (beneficiary mothers, Leader Mothers, and community leaders).

Summary of Discussions with Beneficiary Mothers

The project has helped us to learn how to take care of ourselves and how to improve the health of our children. Before, we used to go the traditional healer, but now we go to the hospital. We have learned to use drying racks, to wash our hands, to burn or bury our garbage, and to use latrines. We have learned to clean a child who has defecated and to properly dispose of the child's feces and was our hands afterwards. We like the "tippy-taps" that we have learned to use when we wash our hands. We've learned that immunizations are important. We've learned to consume nutritious foods when we are pregnant, to obtain prenatal care, and to give birth at the hospital. Before we didn't know that pregnant women need more rest and they need to avoid heavy lifting. There are fewer maternal deaths now. We have learned to take our children to the hospital when they develop danger signs. Before, we didn't know that children with fever need to go to the hospital. We are now making more nutritious meals for our children, using green leaves, adding oil, and using peanuts and sugar.

Now are children are better nourished and not as thin. We have learned to give them fruits, sweet potato, peanuts, beans, cornmeal, bananas, oranges, and tangerines, and exclusive breastfeeding during the first six months. This has helped a lot.

Our children are not as sick as they used to be. They used to be sick all the time with diarrhea. There are fewer child deaths now (especially from diarrhea and malnutrition). Now most of the deaths are from malaria. In our community, there haven't been any child deaths this year. We used to always have a few.

It was difficult for us to continue breastfeeding our child when we became pregnant. We always thought that when we do that we are stealing milk from our growing baby within us. Our mothers-in-law and the older women in the community think they we shouldn't breastfeed while we are pregnant.

We don't know if our Leader Mothers will come to visit us after then project ends. They will probably visit us, but less frequently.

We would like to have a bicycle-ambulance, and we want to learn what they know in other countries.

The project has helped us to change the relationship we have with our husbands. Now they don't insist that we stay in the fields as long and want us to be able to attend project meetings. We have better relationships with our husbands now. We have learned how to show more respect to our husbands and leaders. We are helping our husbands and mothers-in-law more often now.

Summary of Discussions with Leader Mothers (Care Group members)

Our children are growing better and are dying less frequently, and we have fewer childhood illnesses, especially diarrhea, fever and cough. And, our children are better nourished. Before, children used to die because we took them to the traditional healer and not to the hospital. The mothers are now having fewer children than before. Our training was quite good, and the Promoters did a good job of training us. When the project began, we did have some trouble getting the Beneficiary Mothers to understand the importance of the lessons. We did have some trouble accepting the teaching that the feces of children are as contaminated as the feces of adults and should be discarded. We had strong support from the community leaders and from our Promoter, and we didn't have any problems with our work during the past year. If we encounter a child who is not growing well, we will counsel the mother about the different foods she should give the child and if the child doesn't improve we will advise the mother to take the child to the hospital.

We have learned about hygiene and sanitation, drying racks, vitamin A and de-worming, handwashing, exclusive breastfeeding, nutritious complementary foods, continued breastfeeding when the mothers becomes pregnant, and the need for pregnant women to go to the hospital if they develop swollen feet. Most homes now have "tippy-taps."

Mothers now know the importance of taking their children to the hospital when they are sick, and they are now giving birth in the hospital. We used to take children with fever to a traditional health, but now we don't. We used to take children with swelling (kwashiorkor) to the traditional healer, but now we know they need to go to the hospital. The same is the case for bleeding during pregnancy. We know how important latrines, handwashing, and cleaning up feces are. We know how malaria is transmitted, and we know danger signs of pregnancy and for newborns. Our mothers understand the need for growth monitoring.

If we encounter a malnourished child in the future, we will help the mother to give the child more nutritious foods. If that is not successful, we will encourage the mother to take the child to the hospital.

One of the challenges that we faced was that sometimes when we went to make a home visit after we had arranged an "appointment," the mother would not be there. We found that the Beneficiary Mothers would like to have a *capulana*, and many also wanted us to give them soy

milk or a bednet or zinc. Some of the mothers-in-law were doubtful that exclusive breastfeeding was enough nutrition for the child, but they have seen themselves that it works and they are now convinced. Another challenge was getting the mothers to accept that the danger sign, when they occurred, meant that they needed to go to the hospital. This was difficult for them because they often had so far to go. In these cases, we often had to insist and insist that the mother take her child. Often times, pregnant mothers set out for the hospital only when labor developed, and they would sometimes give birth on the way. If we had a problem, we called on the community leaders and our Promoter to help us, and they were always happy to do so. Otherwise, we didn't really have any problems. The messages were easy to understand, and we didn't have problems collecting births and death data. We never found a mother who did not want to participate in the project.

The Promoter provided us with de-worming medicines, zinc for diarrhea, and oral rehydration packets. We like the zinc especially, because it shortened the duration of the diarrhea. After receiving the de-worming medicine, the children are passing worms by mouth and from below, and other people in the community also want this medicine.

We are grateful to the project for all it has done for us. The project did an excellent job of preparing us for our work. We plan to continue our work with our Beneficiary Mothers. The time we have spent working on this project – about 4-8 hours a week – has not been a problem for us because we have been helping our community. (Sometimes, we meet with our Beneficiary Mothers in groups, but sometimes we visit them individually in their homes.) Oftentimes, others come to our meetings and listen to our messages, such as our mothers-in- law. Our husbands are happy with our work, and they are the ones who nominated us for this work. They are happy that our children are healthier and that our houses are cleaner, and that we know when we need to go to the hospital. They are also happy because they didn't have to buy us *capulanas*! They are building latrines for us. They are more likely to take us to the hospital when we are pregnant and have a problem. We are very happy. We like our work because we have benefitted ourselves and because we are helping our community. We are all treating our neighbors better now and showing more love for them.

We plan to remain active after the project ends, continuing our home visits and meeting as a Care Group even though we won't have a Promoter to help us. We will continue to meet with our C-IMCI-trained Leader Mother. We will continue to help sick children. We wish we could have a bicycle like the CIMCI-trained Leader Mother does.

Our Promoter has been a great help. She prays with us, she visits us when we are sick, and she sometimes goes with us to the hospital. She has been patient with us, and she repeats and repeats until we finally understand. She comes to the house if we have a child who is sick and her mother refuses to take the child to the hospital. We appreciate her work so much.

We hope that Food for the Hungry will not leave. We want to learn more! Who is going to teach us? We feel very satisfied with our work because we have learned a lot of important things. This is the first time we have encountered a project like this. All of the other ones give us "things."

Summary of Discussions with Community Leaders

We have liked the project because it has brought many changes to the community such as:

- Better nutrition
- Our newborns are growing better
- We're now taking our children to the hospital[30]
- Mothers now know how to give nutritious foods to their children when they become malnourished
- Drinking clean water (that has been boiled or treated with Certeza, a dilute chlorine product distributed for point-of-use by PSI).

Before, when women were pregnant they didn't go for prenatal care. Before, we didn't practice family planning. Now we do and we have fewer children. Before, it was against our tradition to give newborns colostrums. Now, the mothers know about danger signs, what to do for fever, about water, sanitation and hygiene, including eliminating standing water and cleaning up trash. We have many more latrines than before

When a child dies, they go to visit the mother to give their condolences and to find out why the child died.

When the project started changing all of these things the mortality of our children started to decline. Everyone is aware that child mortality has declined. We now see the fruits of the project. Everyone knows to take their children to the hospital when they develop danger signs.

When the Leader Mothers have problems, they call us and we help them. We last met with them one week ago, and we talked about how to reinforce previous teachings. They let us know about what new lessons they are teaching and when someone is sick. When a Leader Mother finds a sick child in a home that should be taken to the hospital and the mother doesn't want to go, the Leader Mother calls on us to help her convince the mother to take her child to the hospital. We meet with the Leader Mothers not on a regular pre-programmed basis, but fairly frequently.

The Care Group system is good because it is producing good results. We will continue to practice what we have learned in the community. We would like to continue learning more to improve our health. We want to continue improving our latrines. Our mothers and children have learned to eat new foods. I used to think that a baby's feces were clean, but now I know they are as dirty as adult feces.

There are a lot fewer children dying now than before, especially from diarrhea and malaria.

Our biggest remaining problems are related to hygiene and sanitation. We live close to the Caia hospital, so that is not a problem. Most of the time, we get good service there, but sometimes it is not so good.

[30] Throughout, people refer to the local health center as a hospital.

We still have many orphans and vulnerable children (that is, children of parents who are not capable of being good parents). We need the project to continue to help us with these children. The project should also include other people in the community, especially the older people, because they often oppose the project's teachings.

We think the Care Groups will continue after the project ends. We as community leaders will continue to support them. We want all of our mothers to give exclusive breastfeeding for six months to guarantee good health. We would like to have a better water source and a protected well. We would like to see the project reach the entire population of Chemba. We would like the Leader Mothers to teach new topics such as HIV.

Summary of Discussions with Promoters

Mothers are now giving colostrum after they give birth and they are using the hospital more. They know the danger signs we taught them and they use these to decide when to go to the hospital. Mothers used to think that malnutrition required treatment in the hospital, but now they know it can be treated with local foods in the community. Mothers now understand the value of local foods (e.g., pumpkin). Pregnant women are eating eggs now, whereas before it was taboo. Mothers are now more proactive in seeking vitamin A and de-worming medication. There is less malnutrition now, and fewer deaths. There is greater use of family planning.

We as Promoters are very happy, and so are the mothers. We feel like we are almost formal members of the MOH staff. Before we couldn't talk about pregnancy or vaginal bleeding and other topics and we couldn't visit newborns (especially the male Promoters). Now this has all changed. Our greatest reward is seeing that the community can resolve so many of its health problems.

We meet with our Supervisor (*Oficial*) at his office once a month, and at least once a month he comes out to one of the communities where we are working. When we are having a problem in the community, we call our Supervisor and he/she comes to help us. Our Supervisor uses a checklist when he/she is observing our work, and then we go over the findings together. We do the same with our Leader Mothers, and we all find this very helpful.

At the outset we had some problems with the cooperation of mothers and their participation, but the community leaders helped us with this. There is a common belief that giving more liquids when children have diarrhea will produce more diarrhea, so the lessons about diarrhea treatment with ORS were sometimes difficult for them to accept initially. Getting mothers to also accept the value of administering colostrums to their newborn was also a challenge. Other teachings that were difficult were exclusive breastfeeding for the first six months of a baby's life (mothers had a hard time believing that it was sufficient), and they also had trouble believing that a pregnant woman should continue breastfeeding. Sometimes it is still difficult to get mothers to continue breastfeeding when they become pregnant. At times the mothers still ask us to give them an incentive. Even though they don't get it, they still work with us.

Traditional beliefs are very strong. There are local traditions that a woman should have sexual relations with another man to "cleanse" the woman from a major event such as a birth or death or some other untoward event. We worked hard to stop this, and the churches helped us.

At the outset we had difficulty ourselves talking with the Leader Mothers about sensitive issues such as sex and menstruation, but we eventually got over this problem. Also, at the outset some husbands would not let their wives participate in the project, but the community leaders helped us and now this no longer is a problem. Before, mothers could not make a decision about taking her child to the hospital without her husband's permission. Sometimes, the husbands are away for 4-5 days. Now, women are empowered to make this decision because the husbands realize that their child could die if prompt action is not taken.

Domestic violence (husbands beating their wives) has decreased very much. People in the community are a lot better prepared to solve their problems. They have learned how to live better as a family and they are better prepared to solve their own family problems, including their social and economic problems. They would like to learn how to work with orphans and elderly people in the community.

One of the Promoters had to travel 32 km to reach his Care Groups, so he bought his own motorcycle. Another Promoter said she had to travel 2 ½ hours by bicycle to reach her Care Groups. They all would like for the project to have provided each of them with a motorcycle.

There are many fewer child and maternal deaths now.

Our Supervisor is a great help. He/she visits us in the community 2-3 times a month. They help us when we don't know how to do something or when we do it wrong. The supervisory checklists are good, but we learn exactly what we need to do to improve our work. S/he uses very gentle language. We could now do our work without a Supervisor.

Summary of Interview with Ministry of Health District Direct

We met with one District Director who had worked with the project for its five-year duration. He was very enthusiastic about the project and its accomplishments. He said that the Care Groups are very effective. The project serves to provide a link between the MOH and the communities and makes it possible to have two-way communication between the MOH and the community. He wishes the project could serve the entire district and not just a part of it. (At present the project serves 80% of the district.)

We have less malnutrition than before. Patients now frequently arrive with their referral form completed by the Leader Mother or the C-IMCI-trained Leader Mother. We have increased numbers of patients coming to the hospital, and more coming earlier in their illness. We also have more births in the hospital. Behaviors in the community have changed. The community's health is definitely improving.

The MOH has a good relationship with the project. We hold monthly meetings together and the projects shares its monthly report with us.

Our Mobile Team visits each community once a month to provide immunizations and vitamin A, prenatal care, family planning, and a health promotion message. We might be able to

link this team to the Care Groups some way. We have one person in charge of this program. “We are afraid if we adopt the Care Group model that the Care Group leaders will demand a salary.” Perhaps the Mobile Team could meet with the Leader Mothers and give them the message for the month to transmit to all the women in the village.

Lyrics to Songs Sung by Mothers during Our Field Visits

Exclusive breastfeeding song (#1): Mothers, let's exclusively breastfeed our children. It has water to fight thirst. It has vitamins. It has everything the child needs. It protects against illnesses.

Exclusive breastfeeding song (#2): Mothers, let's exclusively breastfeed our children. Breast milk is important. It protects against illnesses.

Testimony song: We are seeing Food for the Hungry's work in our community. Pregnant women are attending and the children are, too.

Food for the Hungry brought good health to our children.

Vision song: God called and we will respond until physical and spiritual hungers are ended worldwide.

Fly song: The fly is the vehicle of illnesses. One of those diseases is cholera. Thanks to Food for the Hungry for being in our community.

Hand washing/“Tippy Tap” song: Mothers, let's wash our hands with soap. When we don't have soap, let's use ashes. In that way, we guarantee the health of our children.

Danger signs during illness song: A child who has sunken eyes, a pregnant woman with hemorrhage, these are danger signs. Pallid hands [anemia] are also a danger sign. (Chorus:) Dangers kill if you don't seek care [go to the health facility].

Thank you God song: Thank you God for sending Food for the Hungry here to resolve our health problems. Good morning.

Song for visitors: We are happy to receive visitors.

Annex 13. Mortality Data and Indirect Estimates of Mortality Impact

Here we present the evidence regarding the project's impact on under-5 mortality. There are two general approaches to this. First is the indirect method recently developed called the Lives Saved Tool (LiST tool), which uses the known efficacy of specific interventions and measures a presumed impact based on changes in population coverage, baseline under-5 mortality rate, and population. The second approach is the direct estimation of mortality changes from the vital events data collected by the project.

LiST Tool Calculations[31]

With the assistance of Tom Davis of Food for the Hungry and Ingrid Friberg of the Johns Hopkins Bloomberg School of Public Health, an estimate of the number of lives saved was computed using LiST. This software is available at http://www.jhsph.edu/dept/ih/IIP/list/index.html. It takes estimates of the mortality impact of specific interventions based on existing evidence and links these estimates to changes in coverage of these interventions, baseline mortality rates, and populations served by a program to estimate the number of lives saved. We computed the lives saved for Areas A and B separately. The LiST Tool estimates that the under-5 mortality rate in Area A has declined by 31.7% between 2006 and 2010, leading to the aversion of 5,032 deaths among children aged less than 5 years of age (Table 14.1). The under-5 mortality in Area B is estimated to have declined by 26.2% between 2008 and 2010, leading to an aversion of the deaths of 1,816 lives of children aged less than 5 years of age. The under-5 mortality rates shown in Table 14.2 are the baseline estimates used for the LiST calculations: 164.4 for Area A in 2005 and 149.6 for Area B in 2008.

Consequently, the total number of lives saved by the project according to the indirect LiST calculator is 6,848. This is an uncorrected estimate since it does not account for the change that would have occurred in the absence of the project.

Table 13.1. Uncorrected Estimates of Lives Saved using the LiST Tool

Districts (Sofala)	Number of beneficiaries	Estimated number of lives saved	Estimated percentage reduction in under-5 mortality rate
Area A (March 2006-December 2010)	92,239	5,032	31.7%
Area B (March 2009–December 2010	127,432	1,816	26.2%
All 7 Districts	**219,617**	6,848	

In order to estimate the number of child deaths averted that can be attributable to project activities, it is also necessary to estimate the number of child deaths averted by the ongoing improvement in child mortality in Sofala province that would have occurred in the absence of the project. According to the 2003 DHS survey, the Sofala U5MR was 205 deaths per 1,000 live births. We estimate that the

[31] Ms. Ingrid Friberg, Assistant Scientist in the Institute for International Programs of the Johns Hopkins Bloomberg School of Public Health provided helpful technical support in the use of LiST and the calculation of the estimates of lives saved by the project.

decline in the U5MR in Mozambique is 3.1% per year. According to the calculations shown in Table 14.2, we estimate that 2,258 deaths of under-5 children had been averted in the project area that were not due to the project activities and that would have occurred in the absence of the project.

Table 13.2. Estimate of Number of Under-5 Deaths Averted as a Result of Ongoing National Trends Unrelated to Project Activities

Year	Estimated U5MR without project interventions	Area A (24,506 births per year) Number of under-5 deaths expected	Number of deaths "averted" by underlying trend compared to baseline year (2005)	Area A 33,842 births per year) Number of under 5 deaths expected	Number of deaths "averted" by underlying trend compared to baseline year (2008)	Total
2005	164.4	4,029	0	5,564		
2006	159.3	3,904	125	5,391		
2007	154.4	3,784	245	5,225		
2008	149.6	3,666	363	5,063		
2009	145.0	3,553	476	4,907	156	
2010	140.5	3,443	586	4,755	308	
Total			1,794		464**	2,258

*Based on a crude birth rate of 49 births per 1,000 population (according to the 2003 DHS survey) in a total population of 500,121 in Area A and 690,643 in Area B.

**For 2009 and 2010 only compared to 2008

With all of this information now in hand, we can estimate the number of lives saved of children 0-59m of age that can be attributable to the project (Table 14.3). The findings from this analysis indicate that 4,590 lives saved (or 67% of the total estimate) can be attributed to the project.

Table14.3. Corrected Estimates of Lives Saved using the LiST Tool

Districts (Sofala)	Estimated number of lives saved using LiST Tool (uncorrected)	Estimated number of lives saved as a result of ongoing trends independent of the project	Estimated number of lives saved that are attributable to project activities
Area A (March 2006-December 2010)	5,032	1,794	3,238
Area B (March 2009–December 2010	1,816	464	1,352
All 7 Districts	**6,848**	**2,258**	**4,590**

These estimates are for number of lives saved of children 0-59m of age. However, the project targeted mothers of children 0-23m of age, so one might argue that the estimates from the List Tool are

overestimating what took place in reality. There are several counter-arguments that one could make to this. First of all, many of the mothers of children 0-23 years of age also had older children, so the benefits provided to these mothers would also benefit their older children. Secondly, at least in Area A, as the project moved beyond each year of functioning, a cohort of mothers "graduated" from the Care Group as their children reached 24 months of age, but the benefits of project provided to this mother continued. And, of course, there is the natural spread of information in the community beyond the Care Group that would lead to behavior change among mothers of older children who were not Care Group members. Finally, we estimate that the U2MR is 80% of the U5MR, so even if there were no impact of the project on children 24-59m of age, the estimates provided by the LiST Tool would only be exaggerated by a relatively small amount. These estimates do not take into account the ongoing benefit of the interventions into the future after the project activities end.

Direct Assessment from Vital Events Data

As described at various sections in the main body of this report, the project implemented a vital events registration activity along with a myriad of other activities. Vital events registration was a part of the original Care Group project developed by World Relief in Gaza Province in Mozambique, and a decline in mortality documented by analysis of vital events reported by Care Group members for the households during the previous month was confirmed by an independent retrospective mortality assessment obtained from pregnancy histories.[32]

The process is quite simple. At the time of each Care Group meeting, a Leader Mother reports to the Promoter whether there were any births and deaths among her Beneficiary Mothers and their children. The age at death and sex of the child is also reported. The Promoter simply tabulates the number in each category for all the Care Groups the Promoter supervises, and then each month this information passes up the supervisory chain.

Unfortunately, minimal attention was given to this data as it was being collected, and little effort was taken to supervise the quality of this data. No vital events were collected in Area A until one year after beginning project operations. In Area B, though, vital events collection did begin at the same time project activities began in March 2009. Although this lack of attention to vital events registration at the outset in Area A is unfortunate, it is completely understandable given all of the other important activities the project was engaged in.

Table 14.4 contains the complete set of vital events data collected by the project along with computed 0-23m mortality rates by month. The under-2 mortality rate (U2MR) has been calculated as the number of deaths of children 0-23m divided by the number of live births for the same period of time and multiplied by 1,000. For months with missing data, we have averaged the number of births (or deaths) for the preceding and subsequent months to provide an estimate in place of the missing data.

There are some limitations of the data which we have to deal with in order to make them useful for analysis. The first is that there are no data reported in January for any of the years of project operation. (This is because the project staff took vacation at this time and did not collect vital events for this month.) The second is that there is one obvious outlier – for the first month of vital events registration in Area B, when 48 deaths were reported and 54 births, giving a calculated 0-23m mortality rate of 889. We have eliminated this month of data from the analysis.

[32] Edward A, Ernst P, Taylor C, Becker S, Mazive E, Perry H. Examining the evidence of under-five mortality reduction in a community-based programme in Gaza, Mozambique. Trans R Soc Trop Med Hyg2007 Aug;101(8):814-22.

For the “cleaned” data, we can observe the number of deaths and deaths reported each month in Areas A and B (Figures 14.1 and 14.2). The number of deaths reported in Area A are consistent with a modest decline over the period of vital events reporting which, as we mentioned earlier, began one full year after project activities began, so any drop that might have occurred during that first year of project activity are not observed with these data. In terms of the births and deaths reported in Area B, Figures 14.1 and 14.2 suggest that the number of deaths show a definite and consistent decline. There is a consistent structure to the age groupings of deaths in Areas A and B (Table 14.5). In both areas, neonatal deaths account for just over a quarter of the deaths, post-neonatal deaths 40%, and 12-23m deaths one-third. The number of births in Area A shows a marked gradual decline while the number of births reported in Area B varied quite erratically.

There is less consistency in the number of births reported. In contrast to Area A, there is no suggestion of a decline in the number of births in Area B (even though there was evidence of increased birth spacing here as shown in Figures 10 and 12 in the main body of the report.

One might make the case based on these data that the reporting of births is unreliable because of the dramatic decline by two-thirds seen in Area A (which seems unlikely in such a short period) and the erratic variation in the number of births reported in Area B, in contrast to a much more consistent trend in the number of deaths reported, taking into account that a major part of the mortality impact in Area A was likely to have already been achieved before the vital events registration system was implemented.

Table 13.4. Births and Deaths among Children 0-23 Months of Age, and Under-Two Mortality Rate by Month and Project Area, March 2007-June 2010

Month	Area A						Area B					
	# of deaths at 0-28d	# of deaths at 1-11m	# of deaths at 12-23m	# of deaths among children 0-23m)	# of live births	0-23m mortality rate (per 1,000 live births)	# of deaths at 0-28d	# of deaths at 1-11m	# of deaths at 12-23m	# of deaths among children 0-23m)	# of live births	0-23m mortality rate (per 1,000 live births)
Mar 07	4	6	3	13	338	38						
Apr 07	9	15	16	40	343	117						
May 07	3	16	9	28	317	88						
Jun 07	8	14	7	29	332	87						
Jul 07	20	22	14	56	345	162						
Aug 07	5	17	8	30	292	103						
Sep 07	5	6	12	23	312	74						
Oct 07	11	12	7	30	327	92						
Nov 07	7	16	11	34	253	134						
Dec 07	2	9	3	14	179	78						
Jan 08				No data (vacation)	No data (vacation)	No data (vacation)						
Feb 08	5	16	4	25	242	103						
Mar 08	0	1	0	1	231	4						
Apr 08	10	22	14	46	309	149						
May 08	9	15	11	35	282	124						
Jun 08	0	0	0	0	203	0						
Jul 08	4	7	4	15	179	84						
Aug 08	10	6	5	21	205	102						
Sep 08	7	6	4	17	147	116						
Oct 08	1	3	2	6	146	0						
Nov 08	10	8	4	22	190	116						

Dec 08	6	5	5	16	167	96						
Jan 09	No data (vacation)	No data (vacation)	No data (vacation)	No data (vacation)	No data (vacation)	No data (vacation)						
Feb 09	2	4	1	7	194	36						
Mar 09	5	10	15	30	101	297	6	21	21	48	54	889*
Apr 09	4	9	7	20	132	152	21	31	24	76	230	330
May 09	4	11	4	19	152	125	9	11	14	34	140	243
Jun 09	6	6	6	18	107	168	13	19	17	49	219	224
Jul 09	7	5	6	18	126	143	13	18	11	42	284	148
Aug 09	6	8	7	21	125	160	4	12	4	20	222	90
Sep 09	4	6	6	16	134	119	8	4	4	16	145	110
Oct 09	0	0	2	2	101	20	5	6	6	17	168	101
Nov 09	5	3	3	11	136	81	2	9	8	19	189	101
Dec 09	2	4	6	10	90	111	2	4	8	14	90	156
Jan 10	No data (vacation)	No data (vacation)	No data (vacation)	No data (vacation)	No data (vacation)	No data (vacation)	No data (vacation)	No data (vacation)	No data (vaca-tion)	No data (vaca-tion)	No data (vaca-tion)	No data (vacation)
Feb 10	5	3	8	16	154	104	3	4	1	9	179	50
Mar 10	4	6	6	16	147	129	2	4	2	8	201	40
Apr 10	6	10	8	24	185	130	9	6	5	20	289	69
May 10	6	8	6	20	162	130	9	6	5	31	260	119
Jun 10				17	146	116				16	260	62

*This rate was excluded in further tabulations since it was obviously an outlier.

Note: The staff members took vacation during January of each year and vital events were not recorded at these times.

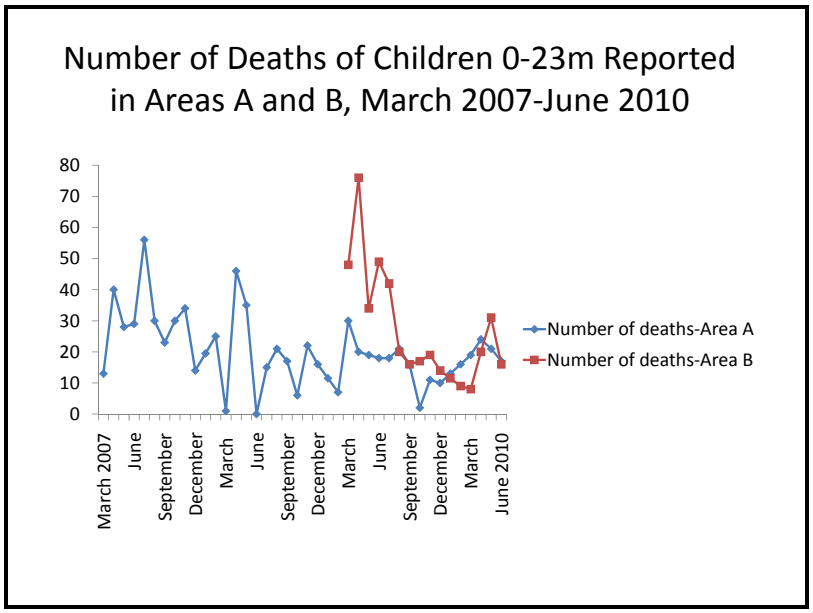

Figure 13.1

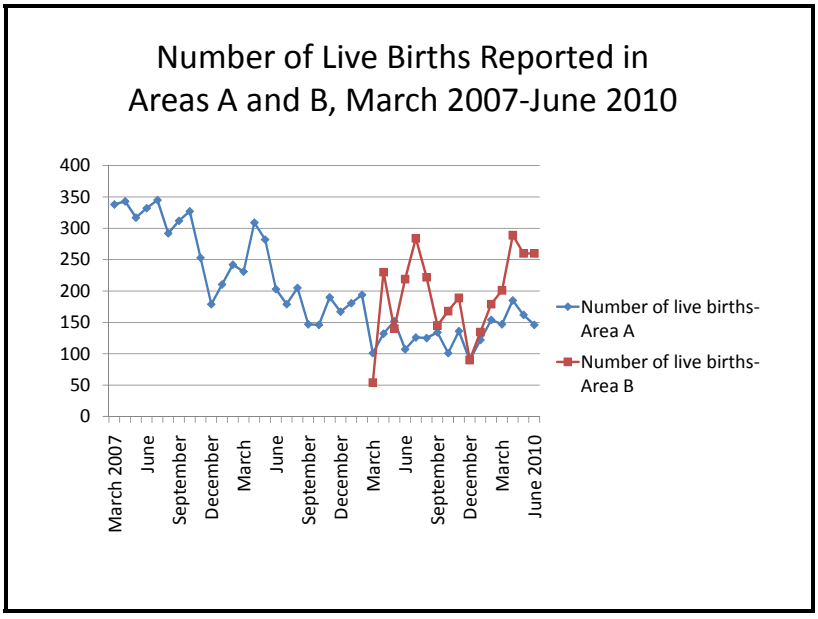

Figure 13.2

Table 13.5. Distribution of Registered Deaths by Age Group

Age at death	Percentage in Area A (n=751)	Percentage in Area B (n=391)
0-28 days	27	27
1-11 months	42	40
12-23 months	31	33
Total	100	100

Table 13.6 provides an expected range in the number of births and deaths that would be expected given the population served by Areas A and B of the project. According to these estimates, the project's vital events register should include 2-3,000 births per month in each of the two project areas and 700-1,000 under-two deaths per year.

Table 13.6. Number of Births and Deaths Expected in the Project Areas A and B at Prevailing Known Rates Based on 2003 DHS Data[33]

Demographic features	Area A	Area B
Project population size	500,121	690,643
Number of births expected (based on a crude birth rate of 49 per 1,000 population)	24,506 per year 2,042 per month	33,842 per year 2,820 per month
Number of under-5 deaths expected (based on an estimated U5MR of 164.4 per 1,000 live births in Sofala Province in 2005 and 149.6 in 2008 as shown in Table 13.2)	4,021 per year 335 per month	5,550 per year 462 per month
Number of under-2 deaths (based on an estimated under-2 mortality rate of 164 per 1,000 live births, 80% of the U5MR)	3,217 per year 268 per month	4,440 per year 370 per month

Comparing the actual number of births and deaths registered per month (in Table3.4) and per year (in Table 13.7) with the number expected (in Table 13.6) shows that only 8-12% of the expected number of deaths were registered and only 7-10% of the expected number of births were registered. Thus, it appears that only a small percentage of the vital events that took place in the project population were actually registered. However, it still could be the case that the reported vital events are accurate for the portion of the population with data, and that this proportion of the population is representative of the total project population. Unfortunately, there is no way we can test the validity of these statements. However, we will make these assumptions and proceed forward with an analysis of the existing vital events data assuming that these assumptions are valid.

For the analysis which we have cited in the body of this report, we estimated the missing values by calculating the average of the values for the previous and the subsequent month. We deleted the March 2009 vital events for Area B in the analysis. We also assumed the rates calculated for 9 months in Area A in 2007 held true for the entire calendar year, and similarly for the rates for 9 months calculated in Area B in 2009. And, we also assumed that the rates observed for the first six months in 2010 for both Areas A

[33]Instituto Nacional de Estatística (Moçambique), Ministério da Saúde (Moçambique), MEASURE DHS+/ORC Macro. MOÇAMBIQUE: Inquérito Demográfico e de Saúde 2003. Maputo, Moçambique: Instituto Nacional de Estatística and Ministério da Saúde; 2005.

and B held true for the entire year, since the project is planning to continue its field activities through most of that period.

The resulting findings are contained in Figures 13.3-4. Figure 13.4 also includes an estimate of the under-2 mortality rate for Sofala derived from DHS data, which we have estimated in the following way. We assume that the under-2 mortality rate is 80% of the under-5 mortality rate. From the 1997 and 2003 DHS surveys, we have estimates of the under-5 mortality rates for the previous 10-year periods.[34] The average decline in under-5 mortality during that period was 2.5% per year. However, for the sake of conservative estimation, we assumed that the under-5 mortality rate began to fall at a rate of 3.1% per year, which is the rate of decline in the U5MR estimate for rural Mozambique by the Multiple Cluster Indicator Surveys (MICSs) carried out in association with UNICEF.[35]

Table 13.7. Births and Deaths among Children 0-23 Months of Age, and Under-Two Mortality Rate by Month and Project Area, March 2007-June 2010, Based on Project Vital Events Registration

Vital event	Area A (37 months of observations)			Area B (15 months of observations)		
	Observed	Expected (from Table 13.6)	% (0/E)	Observed	Expected (from Table 13.6)	% (O/E)
Number of deaths registered through the project's vital events registration system	268	2,220	12.1%	419	5,550	7.5%
Number of births registered through the project's vital events registration system	7,532	75,554	10.0%	2,930	42,300	6.9%

[34]Instituto Nacional de Estatística (Moçambique), Ministério da Saúde (Moçambique), MEASURE DHS+/ORC Macro. MOÇAMBIQUE: Inquérito Demográfico e de Saúde 2003. Maputo, Moçambique: Instituto Nacional de Estatística and Ministério da Saúde; 2005.

Instituto Nacional de Estatística (Moçambique). MOÇAMBIQUE: Inquérito de Indicadores Multiplos, 2008. Maputo, Moçambique: Instituto Nacional de Estatística 2009.

[35] Ibid.

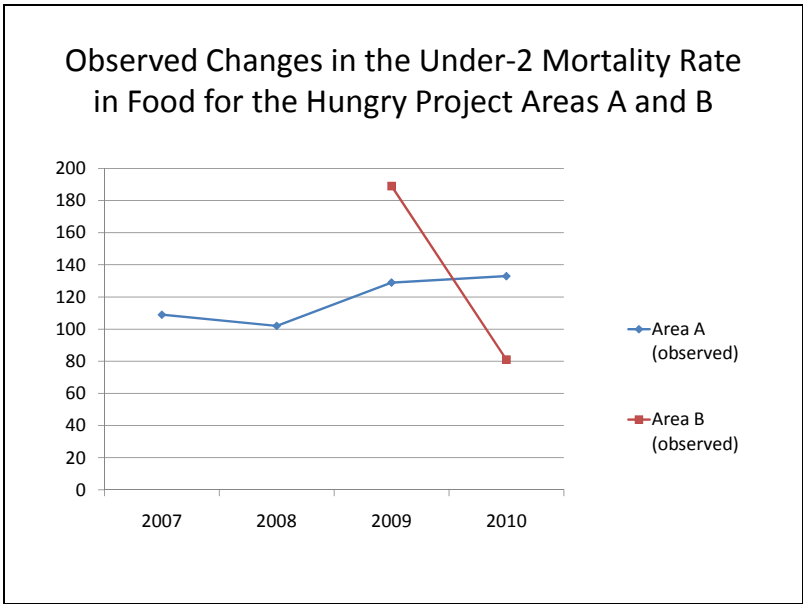

Figure 13.3

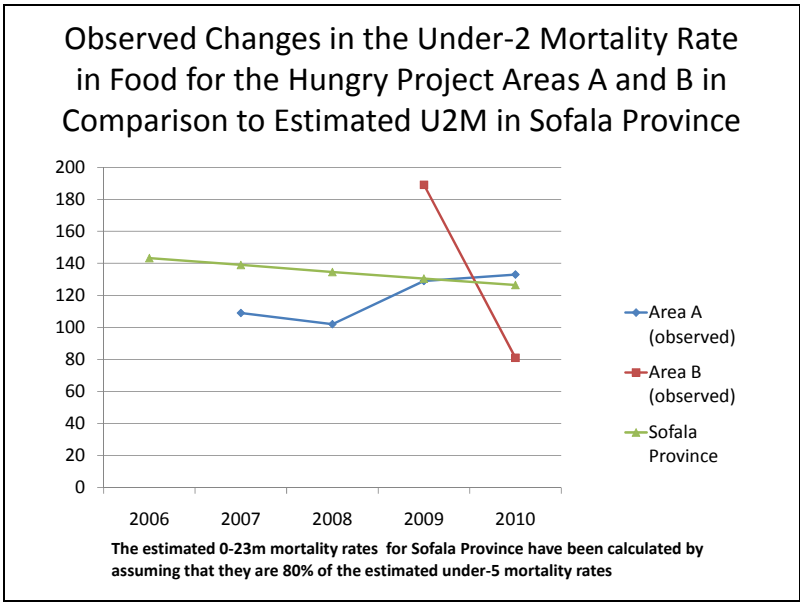

Figure 13.4

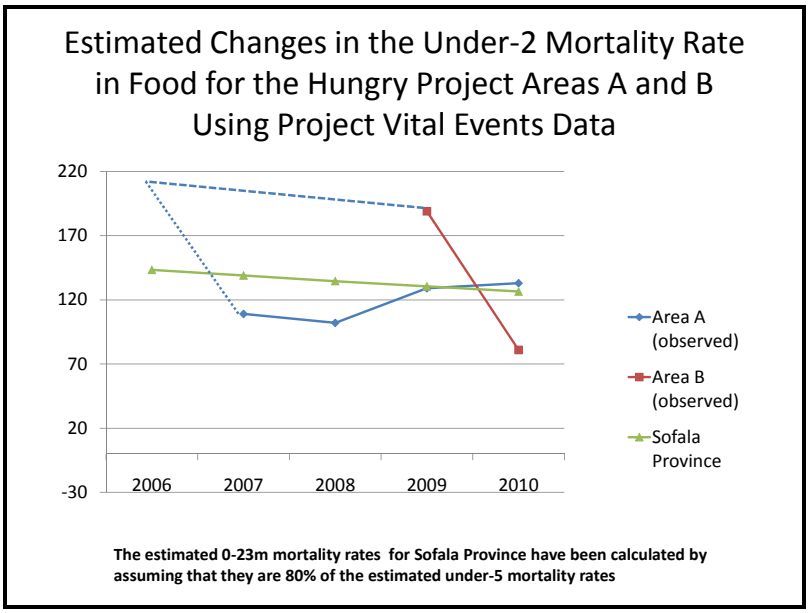
Estimated Changes in the Under-2 Mortality Rate in Food for the Hungry Project Areas A and B Using Project Vital Events Data
220
170
120
70
20
-30
2006
2007
2008
2009
2010
Area A (observed)
Area B (observed)
Sofala Province
The estimated 0-23m mortality rates for Sofala Province have been calculated by assuming that they are 80% of the estimated under-5 mortality rates

Figure 13.5

Taking the findings in Figure 13.5 as our best estimate (based on the project's vital events data) of what actually transpired in the project area (and what the actual U2MR in the project was at the time project activities began), then how many under-2 deaths were averted by the project? Tables 13.7-13.9 provide the answer. In Table 13.7, we limit our analysis to the number of under-2 deaths prevented by the project if we assume that there was no underlying secular change independent of the project. We assume that the decline in mortality is evenly spread over the five years of project operation in Area A and that the final U2MR is 118 (which is the average of the rates for 2007-2010 shown in Figure 13.4.). In Table 13.8 we estimate the number of deaths that were averted by the underlying secular change we assume is occurring (with a reduction in rates of 3.1% per year). Table 13.9 calculates the difference. Thus, we estimate that the project saved 6,598 lives of children aged less than two years over the five years of project activities.

Table 13.7. Estimate of Uncorrected Number of Under-2 Deaths Averted by the Project as a Result of U2MR Declines Estimated from Figure 13.4

Year	U2MR	Area A (24,506 births per year)		Area B (33,842 births per year)		Total
		Number of under-2 deaths expected	Number of deaths "averted" by project compared to baseline year (2005)	Number of under-2 deaths expected	Number of deaths "averted" by project compared to baseline year (2005)	
2005	218	5,342	0			
2006	193	4,730	612			
2007	171	4,191	1,151			
2008	151	3,700	1,642	5,110	0	
2009	134	3,284	2,058	4,535	575	
2010	118	2,892	2,450	3,993	1,117	
Total			**7,913**		**1,692***	**9,607**

*For 2009 and 2010 only compared to 2008

Table 13.8. Estimate of Number of Under-2 Deaths Averted as a Result of Secular U2MR Declines in the Absence of the Project

Year	U2MR	Area A (24,56 births per year)		Area A 33,842 births per year)		Total
		Number of under-2 deaths expected	Number of deaths "averted" by project compared to baseline year (2005)	Number of under-2 deaths expected	Number of deaths "averted" by project compared to baseline year (2005)	
2005	218	5,342	0	7,378		
2006	211	5,171	171	7,141		
2007	205	5,024	318	6,938		
2008	198	4,852	490	6,701	0	
2009	192	4,705	637	6,498	203	
2010	186	4,558	784	6,295	406	
Total			**2,400**		**609***	**3,009**

*Calculated assuming that the U2MR in the project area was 218 in 2005 and that it declined at 3.1% per year thereafter.

*For 2009 and 2010 only compared to 2008

Table 13.9 Estimate of Corrected Number of Under-2 Deaths Averted as a Result of Project Activities

	Number of Deaths Averted
Estimate of number of deaths averted by the project in the absence of underlying secular change (from Table 13.7)	9,607
Estimate of number of deaths averted as a result of underlying secular change (from Table 13.8)	3,009
Difference	**6,598**

In summary, what can we conclude regarding the information we now have about the direct mortality estimates obtained from vital events reported by the project? Interpretation of these finding is not straightforward and requires consideration of several perspectives. First of all, the length of time these vital events have been monitored is too short to be able to observe a definite and substantive demographic effect. Secondly, we have no way of knowing how good the quality of these data is and whether they are representative of the project's population.

Having said that, several conclusions can be drawn nonetheless. First of all, the U2MRs produced by these data are at least "in the ballpark" of what one might expect to find with high-quality data. Secondly, since no vital events were observed in the first year of project operations in Area A, whatever drop in 0-23m mortality might have occurred is not captured by these data. If the correct U2MR for the project area during the year project activities began in 2006 is what we estimate for Sofala province for that year (133.3), then it appears as if there may have been a decline followed by a subsequent increase. However, this does not seem reasonable given the remarkable improvements we have documented in terms of coverage of key interventions, utilization of services, and improvements in nutritional status. The more likely scenario is that the baseline U2M in the project area was actually considerably higher than the DHS estimates for the entire province. This seems reasonable since the project area is more geographically isolated and is inhabited by people with less economic resources and less education than for the entire province. The U2MR data for Area B are for only a 15-month period (although we assume in our analysis that the rates observed in the first half of 2010 in Area B are maintained for the second half of the year since the project intends to maintain operations until the end of the calendar year), so expecting to observe a change during such a short period is unrealistic.

There is a strong indication of a decline in under-2 mortality, however. The rate estimate for the first year is quite a bit higher than the estimate we have for Sofala province as a whole. It is quite possible that the initial U2MRs in the project area were quite a bit higher than we have estimated here. If so, then the direct evidence of a mortality decline as a result of the project would be much stronger than that which we have at present. Unfortunately, the only way to determine this now is by carrying out a retrospective pregnancy history in the project area, which is one of the recommendations arising from this report.

Nevertheless, our best estimate based on vital events data collected by Care Group Volunteers is that the project will have saved the lives of 6,598 children 0-23m of age by the time it ends its work at the end of 2010. This compares to the estimate of 4,590 lives of children 0-59m of age produced by LiST calculations. These are not the same estimates of course, but they both suggest (independently of each other) that the project in fact did save a large number of lives of children.

These estimates (and the LiST estimates) do not include the number of lives that will be saved in the future as a result of the ongoing behavior change, changes in practices, and continued functioning of the Promoters and Care Groups after the project ends – an effect that in fact may save even more lives that was saved during the course of the project itself.

Findings from Verbal Autopsies

In addition to the registration of vital events, the project trained the Promoters to visit mothers of children who died and complete a structured verbal autopsy questionnaire. As with the registration of vital events data, this activity was not a priority and was not closely monitored or supervised. We have chosen to not report this data here.

Estimates of Cost-Effectiveness

Using the LiST Tool and subtracting out the presumed secular trend, we can estimate the cost per life saved and the cost per DALY saved, as shown in Table 13.10. These calculations are all rather straightforward except for the estimate of DALYS averted for each life of a child under-5 whose death has been averted. Others[36] have estimated that 30 DALYS are gained for each death of an under-5 child averted, and we are following that approach here. **Using the uncorrected figures, at a cost of $441 per life saved and $14.72 per DALY averted (including USAID costs and the PVO match), the Care Group intervention implemented by the project is highly cost-effective. (Using the corrected figures, the cost per life saved is $664 and the cost per DALY averted is $22.)**

[36] Bhutta ZA, Ahmed T, Black RE, Cousens S, Dewey K, Giugliani E, Haider BA, Kirkwood B, Morris SS, Sachdev HP, Shekar M. What works? Interventions for maternal and child undernutrition and survival. Lancet2008 Feb 2;371(9610):417-40.

Table13.10. Estimates of Cost per Life Saved and Total Cost Per Beneficiary

	Area A (March 2006-December 2010)	Area B (March 2009–December 2010	Areas A and B Combined (All 7 Districts)
Number of beneficiaries	92,329	126,378	219,617
Estimated number of lives saved using LiST Tool (uncorrected)	5,032	1,816	6,848
Estimated number of lives saved as a result of secular trends independent of the project	1,794	464	2,258
Estimated number of lives saved attributable to project activities	3,238	1,352	4,590
Project costs (USAID costs only)			$2,499,910
Project costs (USAID + PVO match)			$3,024,166
Cost per life saved (USAID costs only), uncorrected			$365
Cost per life saved (USAID costs only), corrected			$545
Cost per life saved (USAID costs + PVO match), uncorrected			$441
Cost per life saved (USAID costs + PVO match), corrected			$664
Cost per DALY averted (USAID costs only), uncorrected			$12
Cost per DALY averted (USAID costs only), corrected*			$18
Cost per DALY averted (USAID costs + PVO match), uncorrected			$15
Cost per DALY averted* (USAID costs + PVO match), corrected			$22
Total cost per beneficiary per year (USAID costs only)			$2.27
Total cost per beneficiary per year (USAID costs + PVO match)			$2.78

*We assume that 1 death averted in a child 0-59m of age leads to the aversion of 30.0 DALYS.

Annex 14. Sample of a Training Aide Used by Care Group Volunteers

Breastfeeding Module

Neste álbum aprenderemos:
Importância do aleitamento
Aleitamento Exclusivo até aos 6 meses de idade
ALEITAMENTO como Prevenção da Malnutrição e Outras doenças
Importância do aleitamento até aos 2 anos de Idade e Introdução à Dieta Complementária

Figure 14.1. Drawings to Complement Breastfeeding Module

Annex 15: Sample of CHW Training Materials

What every family should know about breastfeeding, child feeding, and hygiene

Course overview:

1. Subject: **Importance of good nutrition and growth monitoring: breastfeeding, child feeding, and growth monitoring.**
    a. Practice: Teach back
    b. Holistic Lesson:
2. Subject: **Breastfeeding in the first six months: colostrum, early initiation of breastfeeding, optimal breastfeeding, overcoming challenges**
    a. Practice: Myth and Truth game about breastfeeding and Teach back
    b. Holistic Lesson: Myths and Truths about God's plan for us.
3. Subject: **Child feeding between 6months to 24 months breastfeeding, giving solid foods and active feeding.**
    a. Practice: Preparing good porridges for babies and children and teach back
    b. Holistic Lesson:
4. Subject: **When a child is sick: feeding a child during and after an illness (such as diarrhea)**
    a. Practice: Preparing good home fluids and teach back.
    b. Holistic Lesson:
5. Subject: **Good hygiene to prevent illness: hand washing, waste disposal, food preparation, food storage**
    a. Practice: Hand washing and teach back.
    b. Holistic Lesson:
6. Subject: **Good nutrition for the family: pregnant and nursing mothers, children age 2 to 5 years, and the whole family.**
    a. Practice: prepare and taste (or plan) some balanced menus and teach back
    b. Holistic Lesson:

Pre-Test: Document: Nutrition Pre-Test

Reminder: *At the beginning of each session:*

- *Seat participants so that everyone can see everyone else.*
- *Welcome participants, introduce yourself, and have everyone introduce themselves.*
- *Thank the participants for helping with the program and encourage them in their efforts.*
- *Explain that they are the most important link in the program.*

I. Lesson 1 Importance of good nutrition and growth monitoring: breastfeeding, child feeding, and growth monitoring.

During this lesson we will discuss:

- Why is good nutrition important for babies and young children?
- Why is growth monitoring important?
- What are some good foods for children?
- What more do children need to grow and develop well?

Promoter: *Questions for the mother leaders*

Why is good feeding important for a child?

How can you tell if a child is growing well?

Note: Take time to listen to the mothers and find out what they already know. Don't correct wrong answers at this time. Thank the mothers for sharing from their experiences, and refer back to things they said as you present the lesson. Take care not to embarrass anyone.

Lesson:

Show figure one**: **Ask: Why is good feeding important for a child? As you said in our discussion just now, babies and children need a good diet for many reasons (as much as possible use the mothers' own words to cover these points):

- To be healthy and strong
- To keep warm, be active, to play and work and learn
- To protect against sickness: to be sick less often, to have less serious illnesses if sick, and to recover more quickly if sick.
- To grow and develop well in body, mind and spirit
- (Other correct things mothers said that you can remember)

Show figure two**: **Ask: Why is breastfeeding best for babies and mothers?

As the group members have said, breastfeeding is very important for babies and young children. That's why it's so good that we breastfeed our children. God made us so that we can provide our babies with a food that is perfect for them.

- Breast milk is the only food babies need for the first six months, giving them everything they need.
- Breastfeeding satisfies a baby's hunger and thirst.
- Breast milk provides a perfect balance of nutrients so babies can grow well, keep warm, move and play.
- Breast milk provides special disease protection elements that help a child get sick less often, less severely, and recover more quickly.
- Breastfeeding can prevent a mother from becoming pregnant again too soon.
- Breastfeeding can slow bleeding in a new mother, and can help her pass the placenta more quickly after giving birth, reducing the dangers to the mother from serious bleeding.
- Breastfeeding is free – it doesn't cost a family anything.
- Breastfeeding provides a child with its mother's warmth and love
- (Other correct benefits of breastfeeding that the mothers have mentioned).

Show figure three: ***Ask: What are some very good, nutritious foods in our area (Sofala)?***

- The most important food for babies and young children is breast milk, so the mother breastfeeding her baby is shown in the center of the picture
- When a child is ready to eat other foods in addition to breast milk (at 6 months of age) it is time to add good mixed porridges and nutritious mashed foods to the child's diet.
- Some very good foods in our area include: maize, whole grains, broccoli, pumpkin, cassava, fish and beans. Children eating these foods are less likely to be malnourished.

Show figure four: ***Ask: How can we tell our children are growing well?***

- It is very important to take our children to be weighed and measured to make sure they are growing well. Young babies need frequent growth monitoring, and older babies still need to be weighed regularly.

- If children are not growing well, it is very important to try to find out why not, and to follow the health worker's advice to remedy the problem. Otherwise, the child may be in danger of serious illness or death.

Show figure five: In addition to growth monitoring what are other ways we can see that a child is growing well?

- Other signs that a child is growing well include bright shiny eyes, some fat on the body (but no swelling). The child is content after feeding, is seldom sick, and is lively, active and playful.

Show figure six: Ask: **What does a malnourished child look like?**

- Explain that some will be too thin, others too short, and others will have swelling that makes them appear fat.
- A malnourished child does not have much energy to play, and gets sick easily.
- Talk about the difference between healthy fat and swelling (swollen faces, hands, feet, or swollen distended bellies are all signs of malnutrition, NOT signs of good growth).
- (Other correct signs that the mothers have mentioned).

Ask: What does a child need in addition to good feeding to grow and develop well?

Figure seven: Loving home: A loving and caring family, A clean, safe home, Safe water, Encouragement to play and learn

Figure eight Health care when sick

Figure nine Protection from accidents and infection

Figure ten Vaccination to prevent many serious diseases

Also re-state other correct things mothers have mentioned that children need.

Summary: Review main points with the group, using the flip chart.

1. *Why is good feeding important for a child?*
2. *Why is breastfeeding best for babies?*
3. *How can we tell our children are growing well?*
4. *What are some nutritious foods in our area?*
5. *What more does a child need to grow and develop well?*

Questions and Answers: Ask the mothers what questions or doubts they have about the lesson. Discuss issues they are confused about. Also, tell them that they will be learning more about the topics in the coming weeks. Next week we will be talking more about breastfeeding.

Activity: Assumptions (this is adapted from Assumptions activity, p. 49 in PD/Hearth Manual).

1. Ask group to list what they believe to be the main causes of malnutrition. Write these down if paper and markers are available.
2. Challenge the group to identify which causes are "assumed" and not necessarily true.

- If it has not already been mentioned, ask the group to consider whether or not a rich child can become malnourished.
- Ask them to think about whether a poor child can be well nourished.

3. Discuss how nutritional status is not necessarily directly related to economic status.
   - People with more money may buy unhealthy treats, instead of giving their children good foods.
   - People who are poor may feed their families inexpensive foods that are very nutritious.

Practice: Have mothers break into groups of two or three, and practice teaching each other the main points from the flip chart.

II. Lesson 2 **Breastfeeding in the first six months: colostrum, early initiation of breastfeeding, optimal breastfeeding, overcoming challenges**

Reminder: *At the beginning of each session:*

- *Seat participants so that everyone can see everyone else.*
- *Welcome participants, introduce yourself, and have everyone introduce themselves.*
- *Thank the participants for helping with the program and encourage them in their efforts.*
- *Explain that they are the most important link in the program.*

During this lesson we will discuss:

- Why it is important to begin breastfeeding soon after giving birth.
- Why babies only need breast milk in the first six months of life.
- Ways to solve some common breastfeeding difficulties.

Promoter: *Questions for the mother leaders*

How soon after giving birth do mothers here usually begin breastfeeding their baby? Why do you think that is so?

Note: Take time to listen to the mothers and find out what they already know. Don't correct wrong answers at this time. Thank the mothers for sharing from their experiences, and refer back to things they said as you present the lesson. Take care not to embarrass anyone.

Lesson:
Ask: ***When is the best time to begin breastfeeding after giving birth?*** Listen to the mothers' answers.

Then Show figure eleven and explain: Many mothers are surprised to learn that it is best to begin breastfeeding as soon as possible after giving birth, within the first thirty minutes. Some people have heard that they should wait longer, but now, doctors, nurses, health care workers and mothers are all learning that the sooner the better. There are many reasons why it is important to breastfeed as soon as possible:

- Breastfeeding helps the mother's womb contract to pass the placenta and to reduce blood loss in the new mother.
- Breastfeeding right away helps the child receive a special kind of breast milk, called colostrum.
- Breastfeeding early and often encourages the mother's body to make more milk, more quickly so that she will have a plentiful supply of milk for her child.
- *Colostrum* is especially made for the newborn baby. It is special milk that is very nutritious.
- Colostrum gives the baby energy and protein, to keep warm and grow, and gives protection against infections and illness.
- Colostrum is very gentle to the baby's stomach and easy to digest
- Colostrum helps the baby pass the first bowel movements, which are a very dark and sticky stool and prepares the baby's stomach for regular breast milk.

Ask: *How often does a young baby need to eat?* Listen to the answers the mothers give. Then show them the pictures (**Show figure twelve)** and explain that a young baby needs to eat very often to grow well. Its stomach is very small and can't hold a lot of milk. Small babies need to eat very often, 10 to 12 times in a day and a night. This means that the young baby will be ready to eat every one to three hours. As they grow, they may go longer without getting hungry, but a three month old baby will still need to feed six or more times in a day and a night.

- Mothers should breastfeed a baby whenever it shows signs of hunger, and should wake a baby up and encourage it to feed if it sleeps too long without eating.
- Mothers should make sure the baby empties the first breast well before giving the second breast. Mother's can rub their babies and talk to them, to encourage them to keep eating.
- (Other correct things about breastfeeding that the mothers have mentioned).

Ask: what food or drink should a newborn have?
Show figure thirteen:

- The milk from a mother's breast is the only food or drink a newborn should have, and the only food or drink it needs for the first 6 months of life.
- God made breast milk to be exactly right for babies. Breast milk changes as the child grows, to meet the child's changing needs.
- If a young baby (less than six months of age) is given any foods besides breast milk, it can be dangerous, causing serious diarrhea and other illnesses.
- Giving a young baby (less than six months of age) water can fill up its stomach with water and it won't get enough milk to grow well. Also the water may be impure and can cause illness. It is best to give the young baby only breast milk when it is hungry or thirsty.
- Sometimes special traditional herbal teas or foods are given to babies. But we recommend giving *ONLY* breast milk in the first 6 months. If a mother wants her baby to receive special

herbs or foods the mother should drink the teas and eat the special foods herself, and pass the benefits on to the baby through her milk.

Ask: How can we tell if a baby is feeding well at the breast?

Show figure fourteen:

- The baby latches on well to the breast and the mother feels the baby's mouth pulling or tugging at the breast when it sucks, but feeding is not painful for the mother.
- The baby empties the first breast well before taking the second breast.
- The baby looks satisfied and relaxed or sleepy after feeding

Show figure fifteen and Ask: Did you know that breast milk is not always the same? It is always highly nutritious, but it changes during a feeding, to supply all the babies' needs.

- Colostrum is special milk for newborn babies; it is thick, very nourishing, protects the child from illness, and helps the child to move its bowels. Colostrum may be in many colors: yellow or brown or white or even clear but it is always very healthy for babies.
- After a few days the milk changes and mothers breasts feel very full and heavy. They have a lot of milk in them, and are also swollen. Later on, when this swelling and over-fullness has calmed mothers still are making a lot of milk for their babies.
- At the beginning of a feeding the first milk to come out is high in water and protein. Protein is good for building our bodies. Our bodies also need water, to satisfy thirst and prevent dehydration and to keep healthy. Breast milk provides all the water a child needs. (Note: Sometimes a mother is surprised when a child asks to breastfeed, but only feeds for a minute or two, then doesn't want more milk. Perhaps the child was only thirsty, not hungry. The first milk to come down out of the breast at a feeding is very good at satisfying thirst. It is more watery and thin in appearance than other milk, and is called the foremilk or first milk.
- A little later in the feeding, the second milk, which is a whole milk, with a good mix of water, protein for growth, milk sugars for energy, and a little cream (fat, for energy and to keep the child warm). This milk looks whiter and richer.
- The last mil, or hind milk, is very high in cream. This milk helps a child to gain weight and to grow well. All children need some fat in their diets, and breast milk supplies this fat in the perfect amounts for the young baby.
- These changes in the milk are why it is so important that a baby empty at least one breast very well during a feeding. Many babies will empty both breasts during a feeding.
- If the mother has an oversupply of breast milk, it is better to empty one breast very well than to feed the child at both breasts every feeding. The child may be gassy and fussy, and not gaining weight well, in spite of the abundant milk supply, because the child is getting a belly full of the lower fat milk, but not enough cream.
- If the mother doesn't have a good supply of breast milk she could feed until the first breast feels empty, and then empty the second breast, then return to the first breast. The first breast will have made some more milk and cream while the baby fed at the second breast. Also, extra feeding will encourage the mother's milk supply to increase.

Show figure sixteen: Ask: *What are some problems mothers may have when breastfeeding?*

Explain that most breastfeeding problems have a solution, if a mother gets the help and advice she needs to solve the problem. Someone who knows and understands a lot about breastfeeding should be able to help -- for example: an experienced mother, older woman, community health worker, traditional birth attendant, nurse or a doctor. In the case of problems it is important to **continue breastfeeding** and seek help.

Some common challenges include:

- Sore nipples
- Low milk supply or sometimes, too much milk
- Blocked milk flow and breast infections
- Becoming pregnant again
- Having more than one baby
- Mother or baby are sick

1. Sore nipples are most often caused by the baby not latching on correctly. The baby should be encouraged to open its mouth well and take a lot of nipple into its mouth. If it isn't latching well, it pinches the mother's breast so the milk doesn't flow freely, and causing pain for the mother.
2. Sore nipples can also be caused by a yeast infection. This is common in warm moist climates. Bathe the nipples with clear water after breastfeeding, and dry them gently with a clean cloth. This may help them clear up. Sunshine on the breast can also help (just a few minutes). If there is no improvement, and the skin is painful, seek help: an antifungal cream may be needed from the clinic.
3. If a mother has a low milk supply she should be sure the baby empties her breasts very well at each feeding, and should breastfeed more often. This will help to increase her supply within two or three days. Eating a little more food and resting more are also helpful in increasing the milk supply. It is usually best not to give the baby other foods or liquids when trying to increase the milk supply. In serious cases, seek medical advice.
4. If the mother has too much milk, or an overabundant milk supply, having the child empty only one breast per feeding, can help to calm the milk supply, as well as making sure the child receives the creamy hind milk. The mother can give both breasts if the child needs more milk, being sure to empty the first breast first.
5. In case of blocked milk flow and breast infections, sometimes this can be treated at home, by using warm cloths and massage to remove the blockages. The mother should continue breastfeeding frequently and rest in bed. If the blockages remain for more than 24 hours, or if the mother is ill and feverish, she should seek care at the clinic, and may need medication.
6. If the mother becomes pregnant again, her nipples will feel tender and sensitive, and breastfeeding will be less comfortable.
    - Many people used to believe that it was necessary to wean the baby when the mother became pregnant, but now we have learned that weaning can be harmful or dangerous for a young child who is not old enough to eat other foods well.
    - If the mother decides to wean, she should do so gradually and slowly while encouraging the young child to learn to eat other nutritious foods -- rapid weaning is not recommended.
    - To continue breastfeeding while pregnant, it is helpful if the mother can eat a little extra food, and rest more.

- If the mother has other health issues or complications in her pregnancy, she should seek medical advice about breastfeeding while pregnant.
- In most cases, the mother can continue to breastfeed and make good milk for her baby, and this will not harm the mother, the nursing child, or the unborn child.
- It is even possible to continue to nurse the older baby alongside the new baby, after it is born, without harm to either child.
- Mothers can also make plenty of milk for twins or triplets.

7. If the mother or the baby become sick, in most cases it is best to continue breastfeeding.
    - In certain illnesses, such as tuberculosis medical advice is needed, about the risks of infection versus the risks of weaning, but in most illnesses in mother or child it is best to keep breastfeeding.
    - Breastfeeding has special elements in it to prevent illness in the child and to help the child get well quickly.
    - Breastfeeding also lets the mother rest while she feeds her child, so she can get well quickly.

Summary: Review main points with the group, using the flip chart.

1. *When is the best time to begin breastfeeding after giving birth?*
2. *How often does a baby need mothers' milk?*
3. *Why should a baby receive only breast milk for the first 6 months?*
4. *How can we tell if a baby is feeding well at the breast?*
5. *How does breast milk change during a feeding?*
6. *What can a mother do if she has problems breastfeeding?*

Questions and Answers: Ask the mothers what questions or doubts they have about the lesson. Discuss issues they are confused about. Tell them that next time we will be talking more about breastfeeding and child feeding between ages 6 months and 24 months.

Practice: Myth and Truth Game: Instruct mothers to listen to the statement that the group leader will read and wait for a signal. Then the group can shout out "yes" or "no" afterwards. Quickly make sure everyone understands the answer before moving on to the next question, but don't embarrass anyone for giving the wrong answer.

Add some local myths or misconceptions about breastfeeding to the list as well. For example in some places woman have heard that they cannot breastfeed when they are angry, or that colostrum is bad.

Myth and Truth Game:

1. It is best to begin breastfeeding right away after giving birth. (YES)
2. If a mother has sore nipples she should stop breastfeeding. (NO)
3. Mothers can breastfeed even if they become pregnant. (YES)
4. Most breastfeeding problems cannot be solved. (NO)
5. Sick children should continue to breastfeed. (YES)
6. Breast milk contains everything a child needs for the first six months of life (YES)

7. Mothers should encourage the child to empty the breasts well (YES)
8. If the mother is ill or tired she should rest and not give the child her breast (NO)
9. Giving other liquids or foods to a baby under six months of age can cause diarrhea and poor growth. (YES).
10. God has given us a perfect food for babies – breast milk. (YES).

Teach the group the new breastfeeding song.

III. Lesson 3: **Child feeding between 6months to 24 months breastfeeding, giving solid foods and active feeding.**
   a. Practice: Preparing good porridges for babies and children and teach back
   b. Holistic Lesson:

Reminder: *At the beginning of each session:*

- *Seat participants so that everyone can see everyone else.*
- *Welcome participants, introduce yourself, and have everyone introduce themselves.*
- *Thank the participants for helping with the program and encourage them in their efforts.*
- *Explain that they are the most important link in the program.*

During this lesson we will discuss:

- Why is it important to continue breastfeeding for two years or longer?
- When is a child ready for other foods in addition to breast milk?
- How can we prepare good porridges for young children?
- How can we encourage young children to eat well?

Promoter: *Questions for the mother leaders*

When a child is old enough to eat other foods and liquids, why is it important to continue breastfeeding?
How can you tell when a child is ready to start eating porridge?

Note: Take time to listen to the mothers and find out what they already know. Don't correct wrong answers at this time. Thank the mothers for sharing from their experiences, and refer back to things they said as you present the lesson. Take care not to embarrass anyone.

Lesson:
Show figure seventeen: **Ask: What is the most important food for young children?**

- Breast milk is the most important food for young children. It is the only food or drink babies need for the first six months of life, and it is still the most nutritious food for young children even when they begin eating other foods.
- That is why mothers should breastfeed babies first before feeding them porridge.
- That is also why it is recommended that mothers breastfeed their children for two years or longer.

Ask: How can you tell a child is ready to eat foods in addition to breast milk? How do you begin offering foods to a child?

Around six months of age, children begin to show a sign of readiness to eat more things than just mother's milk.

- They may be beginning to sit up on their own, and may be getting teeth.
- They may be showing interest in what the family is eating and trying to put things in their mouths.
- They are old enough to control their tongues and swallow food without choking on it.
- (Other correct suggestions about feeding a child that the mothers have mentioned).

What should the first porridges for a child be like? (*Papinhas liquidas*)

Show figure eighteen

- As a baby is just learning to eat, the first porridges will be thinner and soupier.
- The porridges should have a base of whole grain, such as maize, oats, millet, bulgur, or barley.
- A vegetable such as pumpkin or sweet potatoes, that is rich in vitamins, and easy to mash up well is a good addition to the first porridges.
- Many mothers like to add some milk from their breasts to sweeten the porridge and help the baby learn to like it, because of the familiar taste. It also makes the porridge more nutritious.

How should a mother begin teaching her baby to eat?

- Prepare a simple, thin porridge such as one made of oats, pumpkin, and breast milk.
- Breastfeed the baby before offering food.
- Sit the baby on the mother's lap, and offer a few tastes of porridge.
- Do not force the baby to eat, make feeding a happy, loving time.
- At first give the baby enriched porridge one time a day, and gradually increase to two times a day.
- Encourage the baby to take more porridge, and to learn to eat well.
- Gradually make the porridges thicker and encourage the baby to eat a larger portion.
- Begin to offer the baby 1 plate of mashed foods shared from the family dish for one meal, and 2 meals of enriched porridges.
- Continue to breastfeed first before feeding the child. Breast milk is still the most nutritious and perfect food for young children, even when they are eating other foods.

Show figure nineteen: ***Ask: What should the food for an older baby be like?***

As a baby grows and learns to eat well, they will begin to eat more foods.

- A child of nine months may be ready to share the family dish 2 times a day (while being helped to eat) to continue to eat enriched porridges 2 times a day as snacks. The child should still breastfeed before eating.

Show figure twenty:

- A child between 1 year and 2 years of age will begin to eat 5 times a day – 3 meals (from the family dish) and two snacks of enriched porridge, while continuing to be breastfed.
- The child should continue to breastfeed up to two years of age or longer.
- The young child's stomach is small, and is not able to hold a large quantity of food at one time. This is why the child needs to eat frequently in order to grow well.

Show figure twenty one: ***What are some healthy foods for children in our area?***

- Some very good foods in our area include: *maize, whole grains, broccoli, pumpkin, cassava, fish and beans.* Children eating these foods are less likely to be malnourished.
- Whole grains include *maize, oats, millet, bulgur, or barley.*
- Protein foods include *fish and beans*, also: ground nuts, seeds or nuts (sesame seeds, pumpkin seeds, almonds, ground nuts, or other nutritious seeds and nuts), legumes (any beans, cowpeas, pigeon peas, lentils) liver, kidney, meats, cheese or eggs.
- Vegetables: *Broccoli and pumpkin*, also: sweet potato, kale, spinach, collards, turnip greens, cassava, tomatoes and tomato paste, palm hearts
- Molasses, tomato paste and cocoa also are nutritious and may be added to some foods or drinks to make them taste good so the child will eat well and have a good appetite.

What are some good recipes for enriched porridges?

- The porridges should have a base of whole grains, such as maize, oats, millet, bulgur, or barley.
- The porridges should provide orange or green vegetables with Vitamin A
- The porridges should provide protein rich foods, such as fish or beans.
- The porridges should contain some oils or fats (*gordura*) from seeds or ground nuts, or added oils. If oils are available – 1 teaspoon of oil added to the child's portion of porridge.
- Remember to include a variety of nutritious foods. Sometimes it helps mothers to remember about variety to tell them about a colored bowl: Put foods of many colors in the child's bowl.

Show figure twenty two: *Here is one recipe for a good first porridge: oats, pumpkin, and mother's milk, with a little boiled water if needed to make it thin enough for a child who is just learning to eat.*

- Be sure to mash everything until it is very soft, as if it has already been chewed.

- The porridge should have a base of whole grain such as maize, oats, millet, bulgur, or barley
- A vegetable such as pumpkin or sweet potatoes, that is rich in vitamins, and easy to mash well, is a good addition.
- Many mothers like to squeeze milk from their breasts into the first porridge to add protein and nutrition, and to make the porridge taste sweeter and more familiar to the child.
- Something with protein, such as lentils or beans, or ground nuts could be added.
- Sit the child on the mother's lap and give a taste of porridge.
- Make feeding a loving, happy time.

Figure twenty three: *enriched porridge of maize, pumpkin, and beans and groundnuts*

Figure twenty four: *enriched porridge of maize, fish, and greens, with a little oil*

Figure twenty five: *enriched porridge of oats, broccoli, and ground sesame seeds*

Note to local FHI staff: These porridge recipes should be prepared locally, and tested to be sure they produce a good portion size to nutrient ratio. A small child cannot eat a large volume of food. These porridges can be adapted to rehabilitate malnourished children as well. If they are used for rehabilitation foods make sure the recipes contain 600-900 Calories, 20-26 grams of Protein, and 500 IU or more of Vitamin A in a portion that is appropriate for a small child (no more than 2 measuring cups of food or 4 small teacups or other local household measurement).

Summary: Review main points with the group, using the flip chart.

1. What is the most important food for young children?
2. How do you begin offering foods to a child?
3 How should a mother begin teaching her baby to eat?
4. What should the food for an older baby be like?
5. What are some healthy foods for children in our area?
6. What are some good recipes for enriched porridges?

Questions and Answers: Ask the mothers what questions or doubts they have about the lesson. Discuss issues they are confused about. Also, tell them that they will continue learning more in the coming weeks. Tell them that next week we will be talking about diarrhea, and about feeding a child during and after an illness.

Practice: As a group, prepare and taste some enriched porridges. While the porridges are cooking, have mothers break into groups of two or three, and practice teaching each other the main points from the flip chart.

IV. Lesson 4: **When a child is sick: danger signs, liquids and food for a child during and after an illness (such as diarrhea)**

a. Practice: Practice identifying danger signs, preparing and tasting home available fluids, and teach back.
b. Holistic Lesson:

Reminder: *At the beginning of each session:*

- *Seat participants so that everyone can see everyone else.*
- *Welcome participants, introduce yourself, and have everyone introduce themselves.*
- *Thank the participants for helping with the program and encourage them in their efforts.*
- *Explain that they are the most important link in the program.*

During this lesson we will talk about:

- Determining when an illness with diarrhea has become an emergency
- Treating simple diarrhea at home
- Good fluids for treating diarrhea at home
- Getting sick children to eat and drink more during and after an illness such as diarrhea
- Praying for the sick

Promoter: *Questions for the mother leaders*

Review of Lesson 3

- ***What are some good enriched porridges for children to eat from age 6 months and upwards?***
- ***Why is breast milk so important for children?***
- ***What are some very nutritious foods in our area that can help prevent malnutrition in our children?***
- ***Other (from bible lesson)***

Discussion of local methods

- Ask participants: What do people in your community believe causes diarrhea?
- Which of these beliefs are true and which are not true (discuss each belief)
- How do people in your community usually treat a child who is sick with diarrhea?
- Which of these practices do you think is helpful?

Note: Take time to listen to the mothers and find out what they already know. Don't correct wrong answers at this time. Thank the mothers for sharing from their experiences, and refer back to things they said as you present the lesson. Take care not to embarrass anyone.

Annex 16. Neonatal Home Visitation Checklist

Checklist Used by Leader Mothers for Neonatal Home Visitation

ACOMPANHAMENTO DO RECEN NACIDO NOS PRIMEIROS 30 DIAS DE VIDA															
Na primeira semana visite todos os dias na segunda 3vezes a semana na terceira 2 vezes por semana e na quarta 1 vez a semana															
Umbrigo Vemelho ou cheira mal	**# de Crianca**	**1a Semana**							**2a Semana**			**3a Semana**		**4a Semana**	
	1	1	2	3	4	5	6	7	1	2	3	1	2	1	
	2														
	3														
	4														
Cor amarela ou pus nos olhos	**# de Crianca**														
	1														
	2														
	3														
	4														
Nao consegue mamar	**# de Crianca**	1	2	3	4	5	6	7	1	2	3	1	2	1	
	1														
	2														
	3														
	4														
Baixo peso/prematuro	**# de Crianca**	1	2	3	4	5	6	7	1	2	3	1	2	1	
	1														
	2														
	3														
	4														
Diarrreia	**# de Crianca**														
	1														
	2														
	3														
	4														
Rigidez de nuca /perigo de morte	**# de Crianca**														
	1														
	2														
	3														
	4														
	# de Crianca	1	2	3	4	5	6	7	1	2	3	1	2	1	
	1														
	2														
	3														
	4														
Dificultad para respirar /Tos grave	**# de Crianca**	**1a Semana**							**2a Semana**			**3a Semana**		**4a Semana**	
	1	1	2	3	4	5	6	7	1	2	3	1	2	1	
	2														
	3														
	4														
Bebe Sadio	**# de Crianca**														
	1														
	2														
	3														
	4														
Mandei urgente para hospital	**# de Crianca**	**1a Semana**							**2a Semana**			**3a Semana**		**4a Semana**	
	1	1	2	3	4	5	6	7	1	2	3	1	2	1	
	2														
	3														
	4														

Annex 17. Operations Research I:

Local Determinants of Malnutrition,

Formative Research for Promotion of Breastfeeding,

and

Health Facility Assessments

Study of Local Determinants of Malnutrition

The full report can be found at the following location:

www.caregroupinfo.org/docs/LDM_Study_June_2008.pdf

A narrated presentation on this report can be found at the following location:

http://caregroupinfo.org/vids/ldmstudy/player.html

Food for the Hungry

Role of Formative Research in the Promotion of Exclusive Breastfeeding

April 2009

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Objectives

- Explain the three types of formative research used to develop program messages and guide beneficiary targeting.
- Explain how messages were incorporated into the behavior change methodology

Food for the Hungry

The Problem:

The baseline KPC Survey found that only 17% of infants 0-5 months of age were exclusively breastfed in the last 24 hours.

Food for the Hungry

Project Setting

- USAID Child Survival and Health Grants Program funded ($2.5M w/25% match)
- Expanded Impact Child Survival Project, Oct 2005 – Sept 2010.
- Eight (of 13) Districts of Sofala Province, Mozambique.
- Interventions: Nutrition (70%), Diarrhea (30%) + C-IMCI
- Beneficiaries: 95,196 children 0-59m + 135,994 WRA

Food for the Hungry

Local Determinants of Malnutrition Study (Expanded PD)

- Positive Deviance Studies divide mothers into two groups – those with healthy children and those with malnourished children – and look for differences in practices between the two groups. (Note: Different process/methodology from Hearth PD study.)
- Extensive interviews are done with the families of the children. Child feeding, child care, and health care seeking practices are compared.
- The Positive Deviance study identifies local coping mechanisms that families with healthy children are already practicing.
- Also explored: depression in the mother, intake of specific nutrients (e.g., magnesium, potassium and phosphorus), domestic abuse, alcoholism among family member, and other variables.
- Conducted in 2005 as part of a Title II Food Security program.
- Studied 21 PD children and 33 malnourished children in two communities.

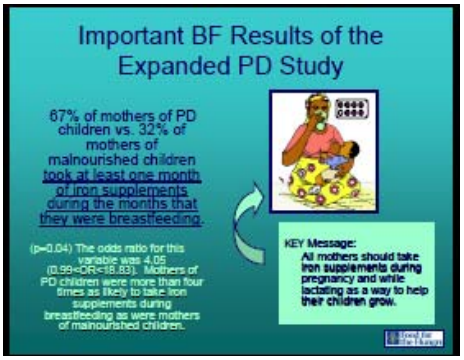
Important BF Results of the Expanded PD Study

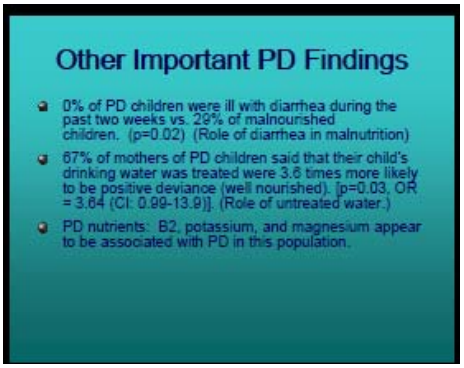
45% of mothers of PD children said that they usually or always completely emptied their breasts when breastfeeding their PD child.

Only 10% of mothers of malnourished children said that they did usually or always do so. (p=0.006) The odds ratio for this variable was 7.09 (1.36 < OR < 48.45) meaning that mothers of PD children were about seven times more likely to do this.

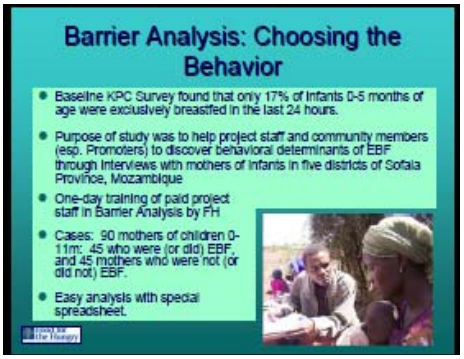
KEY Message: When breastfeeding a child, it is important to always completely empty **each breast so that the** child gets all of the calories and nutrients that they need.

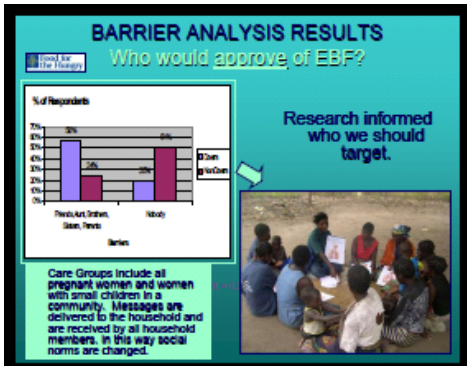
KEY MESSAGE:
The Milk Changes during Breastfeeding.
The longer the child breastfeeds on one breast the richer the milk becomes in protein and fat.
The FIRST milk (watery milk)
The SECOND Milk (normal)
The THIRD Milk (creamy)

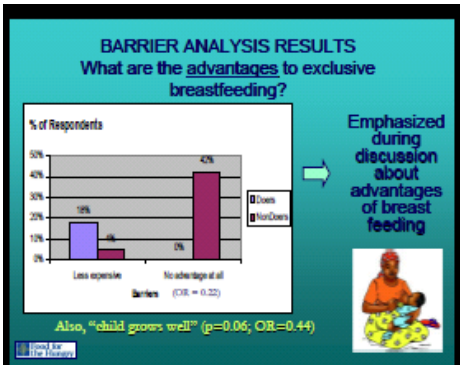

Important BF Results of the Expanded PD Study
67% of mothers of PD children vs. 32% of mothers of malnourished children took at least one month of iron supplements during the months that they were breastfeeding.
(p=0.04) The odds ratio for this variable was 4.05 (0.99<OR<16.83). Mothers of PD children were more than four times as likely to take iron supplements during breastfeeding as were mothers of malnourished children.
KEY Message:
All mothers should take iron supplements during pregnancy and while lactating as a way to help their children grow.

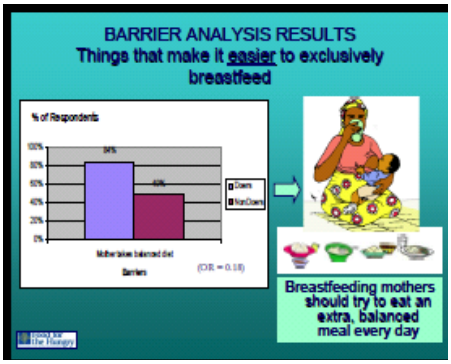

Other Important PD Findings
0% of PD children were ill with diarrhea during the past two weeks vs. 29% of malnourished children. (p=0.02) (Role of diarrhea in malnutrition)
67% of mothers of PD children said that their child's drinking water was treated were 3.6 times more likely to be positive deviance (well nourished). [p=0.03, OR = 3.64 (CI: 0.99-13.9)]. (Role of untreated water.)
PD nutrients: B2, potassium, and magnesium appear to be associated with PD in this population.

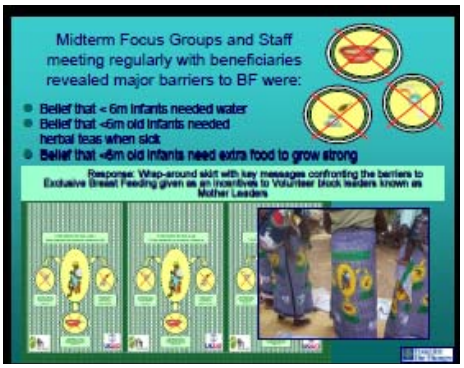
Method: Barrier Analysis
http://barrieranalysis.fhi.net
What is it?
• Rapid assessment tool used to identify the most important behavioral determinants (from Health Belief and Theory of Reasoned Action models) associated with a particular behavior.
• Used to develop more effective behavior change communication messages & activities.
• Compares Doers and NonDoers.
• Developed in 1990 (by Tom Davis) and modified based on AED's BEHAVE Framework and Doer/NonDoer Analysis.
Behavioral Determinants Examined with Barrier Analysis
Perceived Severity
Perceived Susceptibility
Perceived Action Efficacy
Perception of Divine Will
Cues for Action
Perceived Social Acceptability
Perceived Self-efficacy
Positive & Negative Attributes


Barrier Analysis: Choosing the Behavior
Baseline KPC Survey found that only 17% of infants 0-5 months of age were exclusively breastfed in the last 24 hours.
Purpose of study was to help project staff and community members (esp. Promoters) to discover behavioral determinants of EBF through interviews with mothers of infants in five districts of Sofala Province, Mozambique
One-day training of paid project staff in Barrier Analysis by FH
Cases: 90 mothers of children 0-11m: 45 who were (or did) EBF, and 45 mothers who were not (or did not) EBF.
Easy analysis with special spreadsheet.

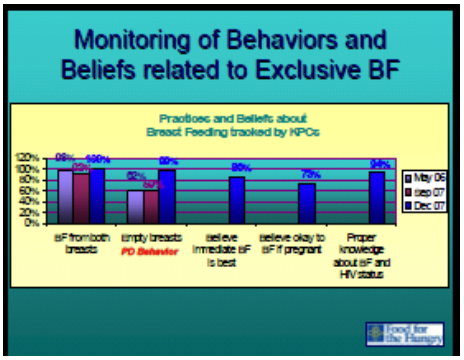

BARRIER ANALYSIS RESULTS
Who would approve of EBF?
% of Respondents
Research informed who we should target.
Care Groups include all pregnant women and women with small children in a community. Messages are delivered to the household and are received by all household members. In this way social norms are changed.

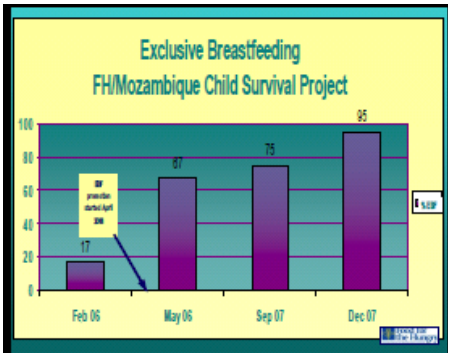

BARRIER ANALYSIS RESULTS
What are the advantages to exclusive breastfeeding?
% of Respondents
50%
40%
30%
20%
10%
0%
18%
4%
42%
0%
Doers
NonDoers
Less expensive
No advantage at all
Barriers
(OR = 0.22)
Emphasized during discussion about advantages of breast feeding
Also, "child grows well" (p=0.06; OR=0.44)

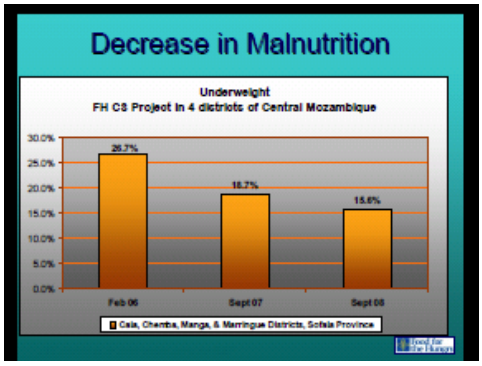

BARRIER ANALYSIS RESULTS
Things that make it easier to exclusively breastfeed
% of Respondents
100%
80%
60%
40%
20%
0%
84%
63%
Doers
NonDoers
Mother takes balanced diet
Barriers
(OR = 0.18)
Breastfeeding mothers should try to eat an extra, balanced meal every day

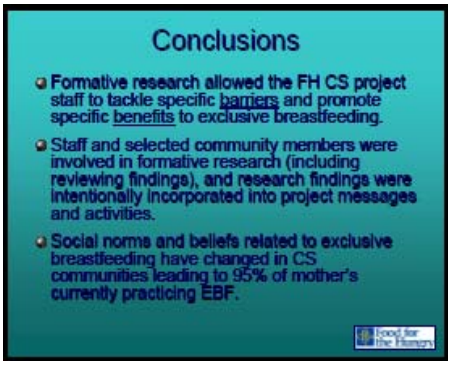

Midterm Focus Groups and Staff meeting regularly with beneficiaries revealed major barriers to BF were:
Belief that < 6m infants needed water
Belief that <6m old infants needed herbal teas when sick
Belief that <6m old infants need extra food to grow strong
Response: Wrap-around skirt with key messages confronting the barriers to Exclusive Breast Feeding given as an incentives to Volunteer block leaders known as Mother Leaders

One of the Keys to Success
– according to the Project Manager
90% of CS staff are from the communities where they work. The first people who had to be convinced of the message were the ones who were responsible to pass it on.
It took time, for staff to see that an exclusively breastfed child was really healthier than one who was given water, teas, and porridge.


Monitoring of Behaviors and
Beliefs related to Exclusive BF
Practices and Beliefs about
Breast Feeding tracked by KPCs
May 06
Sep 07
Dec 07
bF from both breasts
empty breasts
PD Behavior
believe immediate bF is best
believe okay to bF if pregnant
Proper knowledge about bF and HIV status


Exclusive Breastfeeding
FH/Mozambique Child Survival Project
17
67
75
95
Feb 06
May 06
Sep 07
Dec 07


Decrease in Malnutrition
Underweight
FH CS Project in 4 districts of Central Mozambique
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
26.7%
18.7%
15.6%
Feb 06
Sept 07
Sept 08
Caia, Chemba, Manga, & Marringue Districts, Sofala Province


Conclusions
Formative research allowed the FH CS project staff to tackle specific barriers and promote specific benefits to exclusive breastfeeding.
Staff and selected community members were involved in formative research (including reviewing findings), and research findings were intentionally incorporated into project messages and activities.
Social norms and beliefs related to exclusive breastfeeding have changed in CS communities leading to 95% of mother's currently practicing EBF.

Thank you!

Overall Findings, Health Facility Assessment

FH/Mozambique, February 2007

Positives:

- Good advice given on medications, diarrhea, nutrition, and fever/malaria.
- In general, very good communication with patients; very courteous and used the right language.
- All children were weighed.
- Checked vaccination data on majority of the children (75%).
- Gave first dose of medicines in the clinic and showed mother how to do it.
- For chief presenting illness, good advice was generally given
- Nurses sometimes checked all danger signs, and usually checked a few of them
- Screened children to look for most severe cases to see first
- Sometimes used open-ended questions on medication dosing
- Sometimes gave ORS in the clinic
- Sometimes took weight into account when calculating dosage.

Opportunities for Improvement:

- Need to assess breathing (listening for stridor, looking for chest indrawing) and respiratory rate on all children with respiratory symptoms. It's easy to miss a case of pneumonia when you do not count respirations.
- Need to assess for all four IMCI illnesses; not just presenting complaint.
- Do assessment of all danger signs on all children.
- In general, assessments should be more thorough. Use the IMCI chart to help.
- Assess home feeding and give every parent advice on home feeding (more liquids/breast milk, continued feeding).
- Use thermometer on every child with a history of fever.
- Need to find ways to give medicine to children without having them choke on it (and possibly aspirate on the medicine).
- Do malaria tests on all children with fever.

Indicator Results from FH/Moz Health Facility Assessment (Feb 07)

	Indicador	Proportion
A	Proportion of children evaluated for the four danger signs (Lethargic/difficult to awake, unable to drink/breastfeed, vomits everything, convulsions)	20%
B	Proportion of asleep/unconscious children who were evaluated for lethargy: (no children were asleep/unconscious)	-
C	Proportion of children evaluated for all four IMCI diseases (cough/difficult breathing, ear problems, diarrhea, fever/malaria)	0%
D	Of children with cough/difficult breathing, the number of classification steps (of 5) done properly	1.1 steps; 22% of process
E	Of children with ear problems, the number of classification steps (of 1) done properly	1 step; 100% of process (n=1)
F	Of children with diarrhea, the number of classification steps (of 5) done properly	1.0 steps (20% of process)
G	Of children with fever, the number of classification steps (of 3) done properly	1.8 steps (60% of process)
H	Proportion of children with fever who received a calmative	100%
I	Proportion of cases where the health worker mentioned the majority of danger signs to the caregiver that should have been mentioned	30%
M	Proportion of children whose vaccination card was checked for completeness	75%
S	Proportion of children who were underweight who were correctly evaluated (checking on breastfeeding, other foods given, and feeding during illness) by the health worker	0%
T	Proportion of caregivers of children 0-23m who were asked about feeding/breastfeeding	20%
U	Of children who were given an antibiotic, proportion who received appropriate instructions on dosing	75%
V	Of children who were given an antimalarial, proportion who received appropriate instructions on dosing	100%

W	**Proportion of children who needed referral to a higher level of care who were referred appopriately: *(No children needed referral.)***	-
GG	**Proportion of mothers who were told to give more liquids and to continue breastfeeding their sick child**	**38%**
HH	**Proportion of children with cough / rapid breathing / difficult breathing whose respiratory rate (breaths/minute) was evaluated**	**0%**

Annex 18. Operations Research II: Assessment of Care Group Functioning

Results of
Care Group Operational Research
Internal Copy

Sofala, Mozambique
Research conducted from April to May 2010

As part of the project:

Achieving Equity, Coverage, and Impact through a Care Group Network

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Project Activity Length: October 1, 2005 to September 30, 2010

Data Collection, Data Analysis and Report Writing:

Tom Davis, MPH

Emma Hernandez, RN

Cecilia Lopes

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Carolyn Wetzel, MPH

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Date: June 30th 2010

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Acronyms

BCC	**Behavior Change Communication**
BM	**Beneficiary Mother**
CG	**Care Group**
CS	**Child Survival**
FG	**Focus Group**
KPC	**Knowledge, Practice, and Coverage**
LM	**Leader Mother**
MOH	**Ministry of Health**
OR	**Operational Research**

I. Introduction

The objective of the Care Group Operational Research was to identify the key components to the effective use of the Care Group Methodology. The OR included qualitative and quantitative survey methods to determine if the Care Group methodology was carried out as designed and identified methodological adaptations that occurred based on problems and difficulties that arose.

II. Operational Research Methodology

The research consisted of three components: Focus Group Discussions, the development and implementation of a KPC Survey, and a four day workshop to interpret and draw conclusions from the results of the Focus Group Discussions and KPC Survey results.

1. **Focus Group Discussions** were carried out with eight groups: CS Project Promoters, Leader Mothers, Beneficiary Mothers, Community leaders, Care Group Participants in former DAP II / USAID Funded Food Security project areas, Health Facility Personnel in areas where Care Groups were and were not active from 2006-2008, and CS Project Officials. The objectives, questionnaires, and consolidated results from Focus Group Discussions can be found in Annex 1.
   Focus Groups were led by the five CS Officials using guides developed by Tom Davis in English and translated into Portuguese by Cecilia Lopes. Each Official led ten Focus Groups discussions. An additional focus group discussion was planned with health facility personnel, but MOH personnel were not willing or able to participate in the interviews. Each official led the following FG discussions:

   - 1 Promoter FG
   - 3 Leader Mother FG
   - 5 Beneficiary Mother FG
   - 2 Community Leader FG

   Cecilia Lopes, the CS Project Monitoring and Evaluation Officer, consolidated all the information collected in the FG discussions. The consolidated FG information was used to develop the KPC questions, multi-choice answers and to determine which groups to target in the KPC.

2. The **Knowledge, Practice and Coverage Survey** consisted of three questionnaires. One questionnaire for CS Project Promoters, one for Lead Mothers, and one for Beneficiary Mothers. The questionnaires were developed by Carolyn Wetzel, translated into Portuguese and reviewed and adapted by Emma Hernandez and Cecilia Lopes.

The project was run in two cohorts. Project Activities in Cohort or Phase I started in 2005 when the project began in the districts of Caia, Chemba, Maringue, and Manga and continued until the OR KPC was conducted in 2010. Activities in Cohort or Phase II districts of Dondo, Gorongosa, and Nhamatanda started in 2008 and have continued until the OR KPC was conducted.

Project Districts in Sofala Province, Mozambique	**Care Groups per District**	**Com-parison Areas**	**% Beneficiary Population of each Comparison Area**	**Inter-views per District**	**Total Number of BM interviewed**	**Total Number of LM interviewed**	**Total Number of Promoters interviewed**
Caia	25	Phase I	18.5%	19	19	19	5
Chemba	25		18.5%	19	19	19	5
Maringue	35		26.0%	26	26	26	7
Manga	50		37.0%	37	37	37	9
Total Phase I	**135**		**100.0%**	**100**	**100**	**100**	**25**
Dondo	55	Phase II	31.4%	31	31	31	11
Gorongosa	60		34.3%	34	34	34	12
Nhamatanda	60		34.3%	34	34	34	12
Total Phase II	**175**		**100.0%**	**100**	**100**	**100**	**35**
Total Project	**310**			**200**	**200**	**200**	**60**

Stratified Random Sampling was used to identify 100 LM and 100 BM in both Phase I and Phase II. Interviews of LM and BM were conducted by CS promoters and supervised by CS Officials. Promoters conducted interviews in districts where they were not working with beneficiaries.

All of the CS Promoters were interviewed by FH non-CS staff, one staff member from the FH Agriculture Program and one from the Child Development Program.

Data was entered into Epi Info for Windows under the supervision of Cecilia Lopes, using templates created by Esther Wong. Data was analyzed by Carolyn Wetzel and Tom Davis.

3. Operational Research Workshop and Presentations

Results of both the KPC survey and Focus Groups were shared and discussed during a four day workshop in Sofala Mozambique, attended by one promoter from each of the eight districts, the five project Officials, three nurses from the MOH, the Monitoring and Evaluation Officer, the Project Coordinator, the Zinc OR Coordinator, the Project Manager, the CS US Backstop, and FH Health Program's Director. The results of the KPC were interpreted using the input, experiences, and opinions of the CS field staff. The conclusions reached were shared with individuals from the provincial and national MOH, USAID, and interested NGO's in meetings held in Sofala and Maputo. Success stories were shared and documented by each of the promoters.

III. Operational Research Findings

KPC results can be found in table form in Annex 9.

A. Age and Gender

Leader Mothers were older than expected (average 37.4 years), especially in Phase I with an average age of 41.2 years. Beneficiary Mothers are on average 10 years younger than Leader Mothers. No association was found between the age of the LM or BM and key knowledge. Project field staff felt that older women (>30 years of age) stayed longer with the project and therefore made better LM.

Mean age of Promoter	31.1	28.9	29.8
% of Promoter's who are Female	**28%**	**20%**	**23%**

LM do not have to be pregnant or have a child <2 years of age but this is a requirement for participation in the program as a BM. It is clear than some exception to this rule exists because 4% of BM were neither pregnant nor did they have a child <2 years of age. Project staff said that during the bi-weekly Care Group sessions BM were asked if they had passed out of the project target group. If BM no longer had children >2 years and were not pregnant they were asked to identify a neighbor women who fit the project participation criteria to replace them. The new BM was then registered as part of the CG and the previous BM was allowed to attend meetings but was no longer registered as part of the Care Group.

	PHASE I	**PHASE II**	**PHASE I & II**
Mean age of Leader Mother	41.2	33.7	37.4
% of LM who have children < 2 years of age or are pregnant	**36%**	**50%**	**43%**
Mean age of Mother Beneficiary	29.7	26.2	27.9
% of BM who have children < 2 years of age or are pregnant	**95%**	**97%**	**96%**

All LM and BM are female, but Promoters can be male or female. Most (76%) of Promoters are male. Promoters are nominated by the community where they serve and then interviewed by CS project staff to determine if they meet the qualifications to serve as a promoter. An advantage of

working with male promoters is that when conflicts arise in the community or between LM and their husbands a male promoter can be called by the LM and BM to advocate on their behalf and because of his gender he will be respected and heard.

Project management believes that the percentage of male promoters has grown over time, as female promoters have left their positions because of family needs or pressures.

We asked the participants about any issues that arise from having male Promoters teaching all female groups of Leader Mothers, any barriers that came up, how sexual harassment is prevented and responded to, and how any gender issues are overcome. Participants said that it is not a problem for male Promoters to do home visits (e.g., visiting a LM who missed the meeting, checking on a sick child who was referred), but that they need to choose sincere men who will do what they are supposed to do and not cross the line of what is appropriate. Male promoters are counseled to respect the people's culture, and **FH has rules in place to help prevent problems** (e.g., men not allowed to transport women on bicycles, never go inside house to teach the woman). These rules are developed by the (male and female) Promoters during the trainings. Supervisors also talk to community leaders and **ask them to watch for and report any sexual harassment problems** that they hear about or see. The Promoters know that the community leaders are briefed in this way. Community Leaders know that they can report any problems seen to FH Officials (Supervisors). Mothers are not advised of a way to directly report to FH Officials, but are told to talk to the Community Leaders if there is a problem.

Some possible ways to improve this system would be to **provide the cell number of the Official (or better, another female FH staff member) to all Leader Mothers** and have Leader Mother communicate the reporting procedure to all beneficiary mothers. It may also be helpful to formalize the rules by providing a written copy of them (along with the reporting procedures) to all Promoters and Community Leaders, and communicating them in one of the first lessons in the flipchart. This could be done in a more generic way, talking about how women can report any form of sexual harassment to community leaders rather than singling out the Promoter (which may bring up suspicions).

B. Schooling

Only 58.5% of BM have gone to school, but for the 41.4% of those who have studied 5.1 years of schooling is the average, similar to that of BM. All Promoters have studied, and 34% have studied for more than the ten years (anything more than ten years of study is considered advanced education in Mozambique).

	Phase I	Phase II	Phase I&II
Promoter average years of education	10.5	9.2	9.7
LM average years of education	4.9	4.7	5.4
BM average years of education	5.1	5.2	5.1

C. Perceived and Actual Literacy of Leader Mothers

1. To a degree, **Promoters in Phase I districts over-estimate the literacy of Leader Mothers**. 44% of Phase I Promoters believe that more than 75% of the Leader Mothers can read the messages on the flipchart, whereas only 18% of LMs say that they can read any of the words on the flipchart and 29% of BMs. In Phase II districts, Promoters under estimate the literacy level of Leader and Beneficiary Mothers. 11% of Phase II Promoters believe that more than 75% of Leader Mothers can read the messages on the flipchart, but 25% of LMs abd 21% if BMs say that they can read most or all of the words on the flipchart.

2. Improving Care Group teaching

Participants responded that some Promoters think that they are transmitting a message but people are not understanding it. Others believed that it did not affect the health promotion since they primarily use the drawings on the flipcharts to teach. The suggestions from the participants on how to improve this included:

a. In addition to the pictures, **use more songs** to help mothers remember the key messages. Find out why only 3% of Leader Mothers say that they use songs when they teach (in response to an open-ended question), and encourage them to use more songs. Later, however, participants mentioned that mothers may be using songs, but not mentioning them as "teaching methods" since they do not think of the songs as a teaching method. (Participants also mentioned using more demonstrations, but were unable to think of anything that we promote currently that can be demonstrated that we are not already demonstrating.)
b. **Create a set of flash cards for each Promoter with all of the images corresponding with key messages and use in games.** Have the Promoters use these with Leader Mothers in the form of a game where LMs have to guess the key message associated with each card. Number the cards, and add cards to the game as more lessons are covered.
c. **Intensify the testing of images**, and **test images using a sub-sample of illiterate mothers** who do not have a TV.
d. **Always use the "same mother" in the pictures** used on the flipchart. Avoid changing her clothing or headdress, since that makes it more difficult for mothers to interpret the picture.

e. We discussed some of the **principles of pictorial literacy** (avoid showing just body parts, like disconnected hands doing something in a text box; no "microscope views"), and participants suggested that we take into account those principles more when developing the flipcharts.

f. **Ask Promoters to spend more time explaining the pictures and asking verification questions** of Leader Mothers about the pictures (to check understanding, like "what does the mother have in her hand? What is she doing with it?").

g. **Encourage all illiterate LMs to participate in the free government literacy programs**. (The government is trying to establish a literacy program to teach mothers to read in 30 days.)

h. **Ask the government literacy program staff to use our key messages** in their program.

i. Stress to Promoters (e.g., in trainings) that they will be working with mostly illiterate mothers, and have them gear their teaching to the lowest reading level mothers – that is, the completely illiterate. (**Teach to the bottom, not the middle**.)

C. Years Involved in the CS Project

1. Turnover of Promoters

Per the plan, after the first 2.5 years of the project, Promoters in Phase I areas were reduced by half. There are currently 25 Promoters in Phase I communities, and 35 in Phase II communities. Aside from this planned reduction in staffing, **the annual turnover of Promoters has been about 3.6%**. 84% of Phase I Promoters (where the project has been active since the beginning) have worked with FH for 4 or 5 years. (The project was at year 4.5 at the time of the survey.) 5% had worked for less than one year, 31% had worked for one year, 24% had worked for two years, and 2% had worked for three years.

It is believed that one contributing factor to the low turnover of Promoters is the fact that 90% of them lived for at least three months in the area where they now work before they were hired by FH (as planned).

2. Turnover of Supervisor (Officials) – only 1 of the CS Officials (Supervisors) currently working for FH have worked with FH since the beginning of the CS project. Four of the five Officials who were hired but no longer work with FH were hired by another organization that pays more (e.g., HAI). One Official died. The project management has talked to the other organization that has hired away FH's Supervisors, but they are unapologetic since their organization pays higher salaries. The CS Official that has worked for FH since the beginning of the project worked for FH in a different project and was transferred to the CS project when an opening in Manga became available.

3. Turnover of Leader Mothers – Turnover of LM, as reported by both Leader and Beneficiary Mothers, is a low 3-10%. The top three reasons that LM or BM dropped out of the project according to Leader Mothers and Beneficiary Mothers is 1. Moved to a new area (34% LM, 30% BM), 2. Too busy working (LM 20% /BM 16%), and Lack of Incentives (11% LM, 13% BM). In the Promoter's opinon Leader Mother's dropped out of the program due: 1. Moved to new area (55%), 2 Lack of incentives (18%), 3 Busy working (13%).

4. Replacement of Beneficiary Mothers or Leader Mothers whose children move out of the target age range. Participants were asked how they replaced Beneficiary mothers whose children had surpassed the age range of the program. They said that during their meeting with BM they ask if anyone's children are out of the target group. If a woman indicates her child is out of the age range then she is asked to bring another woman in the community who is pregnant or has a child under 2 years of age to the next meeting. Sometimes women continue assisting meetings even after they have been officially replaced in the group of BM or LM, but others continue to participate. Usually, even if they leave the group for a time, they return because they are pregnant again.

5. Turnover related to migration - there is a turn over of mothers because many families are constantly moving from one area to another. Families seek fertile areas for farming and move to where they can have more agriculture success. Some go and return, others move permanently. Some women move and enlist in other CG in their new community. In Manga, the migration of women, was raised a serious problem. One way Promoters have found to resolve the problem is to avoid enlisting women who rent houses in their community, because they know they will soon be leaving. They prefer to enlist women who own the house they live in.

D. Participation in Teaching Sessions

In the CS program each Promoter is assigned five Care Groups. Each Care Group consists of 14 LM. Every 2 weeks the LM's meet with the Promoter and receive a 2 hour lesson. Then the LMs have two weeks to share the same lesson with their 12 BMs. They are encouraged to share the lesson as a home visit, but they have the option of calling the BM together and sharing the lesson with the group of women.

The KPC survey revealed that this cascade structure of education has been functioning as planned, except that Promoters are reaching slightly less LM than anticipated through group meetings. Promoter's report an average of 12.6 LM present at their teaching session (instead of the 14 planned), this is slightly higher than the average attendance reported by LM (10.7 LM present).

BM report an average of 9.7 BM present at the LM teaching session, but 11.7 BM registered in each of LM groups. Based on these results, it's recommended that the ratio of Promoter to LM and LM to BM be kept between 10 and 14.

BM and LM report respectively that 96% and 98% of BM or LM met every two weeks for health education and behavior change messaging. Promoter's report LM attendance slightly lower at 85% (92% in Phase I districts and 80% in Phase II districts). 78% and 84% of LM and BM respectively report attending most or all education sessions.

1. Follow-up of Leader Mothers who Miss Care Group Meetings

It was not originally anticipated that there would be follow-up with Leader Mothers who miss Care Group meetings. The project leadership, however, felt that this was possible for Promoters and now it is expected of all Promoters. **98.2% of Promoters said that they follow-up with one or more LMs when they miss meetings**, and about two-thirds said that they usually do follow-up with about 2-4 Leader Mothers per session (defaulters) by visiting them in their homes to give the lesson.

2. Length of Meetings

77% of BM and 82% of LM either attending or facilitating group teaching sessions that lasted at least one hour. 80% of Promoters said that the Care Group meetings lasted between 1.5 and 2 hours. 10% said more than two hours, and 10% said less than 1.5 hours. In order to use all the participatory adult teaching methods included in the Care Group Lesson Plan a Care Group meeting would need to be 2 hours long, a shorter meeting would mean cutting out parts of the lesson.

These results confirm that the majority of the Promoters are taking the time to properly teach LM. LM, to a lesser degree, are using the participatory teaching methods when sharing the BCC with BM.

3. Lesson Plans

98.4% of Promoters claimed to use the lesson plan (all but one). We asked participants what (if anything) needed to be changed, added, or removed from the lesson plans to improve them. Participants were happy with the lesson plans and did not suggest any changes, but said that they prefer songs to games since they are easier to use.

E. Ensuring LM's teach BM

Promoter workshop participants were asked how they ensured LM visited their BM. Promoters said that part of their supervision of LM was to go with LM and observe their teaching or follow-up on the teaching with a visit. They said that there have been cases of LM who did not teach BM, but they were not frequent. Normally, if the LM stops teaching BM, the BM will complain to the Promoter and request the teaching.

One promoter shared that she had to replace an IMCI trained LM because she was not doing the IMCI work. The community had a meeting and asked for the LM to be replaced and the Promoter assisted. Another promoter shared that she had to replace a LM per the request of the LM's beneficiaries. The LM was very young and knew how to read and write. She felt that she didn't need to come to the Promoter's trainings because she could read what was written on the flipchart and that it was beneath her to teach the illiterate women in her group. The promoter replaced her with her most active and interested BM.

1. Are LM Assistants commonly used? Participants were asked if LM normally send another beneficiary to represent them when they cannot attend a Promoter led meeting. They said if a LM was going to be absent for some time she sends one of her beneficiaries to receive the lesson. Participants thought that the idea to formalize an a LM assistant could work if the wrap around skirt incentive was prepared for both the LM and her assistant.

E. Group teaching vs. Home visits

Surprisingly more LM share messages through group meetings than home visits. Prior to this survey it was assumed that LM would have difficulty calling mothers together for a group teaching session, but the survey results indicate that 75% of LM share messages mostly or only through group meetings in the opinion of the BMs. 70% of LM reporting sharing messages mostly or only through group meetings.

1. Participation of Other Household Members in Health Promotion Sessions

In response to an open-ended question about who participated in the health promotion lessons when they are done at the household, **78.5% of mothers said that someone else participated aside from the mother herself**. One surprise was that **48.5% of mothers said that their daughters usually participated in the lesson**, an indication that this project is influencing the next generation of mothers in addition to the current one. 14% of mothers said that a friend participated and 10% mentioned the grandmother of the child.

2. Participation of men in the household-level health promotion is rare. Only 0.5% of beneficiary women said that their husbands usually participated in the lessons, 2% mentioned grandfathers, and 3% mentioned sons). Participants say that husbands are simply not usually in the household when Leader Mothers visit. Many also think that the lessons are "women's issues." It would be good to **develop some messages on why the information shared (and behaviors promoted) are important for both men and women**. In terms of who is influential in the home, married women are most influenced by mother-in-laws, and single/divorced mothers are most influenced by grandmothers.

When participants were asked how men learn the CG material, some said the LM or BM share the message with their spouse. Other's said this doesn't work because the husband doesn't give credit to what his wife says. In some cases the men asks what the woman learned and she explains, in other cases the woman herself is excited and shares the new information.

One way the project is currently reaching men is through the bi-annual community leader meetings. During these meetings (which have normally been attended only by men) the CS Project Manager has shared the key CG messages. A debate ensued about the possibility of the Promoter sharing CG messages during regular community meetings. Some participants said this could work, others felt that since normally community meetings are mixed gender events it would not be appropriate to talk about sensitive subjects (eg. vaginal bleeding). Participants felt that sensitive topics were appropriate to discuss in single sex groups, but not in mixed company.

F. Time traveled

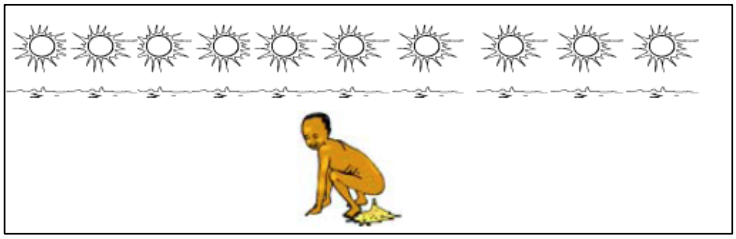
Originally the CS project planned to have half the number of promoters now employed. During the DIP writing process, it was decided that the low population density of the majority of the project districts would require a promoter to travel too far to reach ten groups of LM using a bicycle. Promoters were originally employed half time, at a reduced salary, and told to work with five CG's instead of the ten originally planned.

Average travel time between Promoters and LM and LM and BM is much shorter than project management expected, even considering the reduced workload given to Promoters. The average time a Promoter travels to reach a LM household (on foot or using a bicycle) is 17 minutes. Travel time for LM's to visit BM is even more critical, considering that LMs are volunteers and a light workload is a key component to their continued willingness to volunteer their time. The average time traveled by a LM to reach a BM as reported by BM is 13 minutes and as reported by LM is 17 minutes.

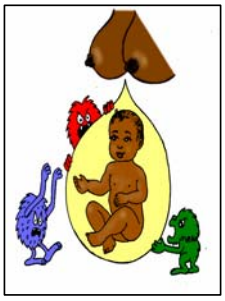
Project participants felt that the LM and BM reporting of "time traveled" could be flawed because they do not possess ways to measure time in minutes or even hours.

G. Recognition of key messages using images

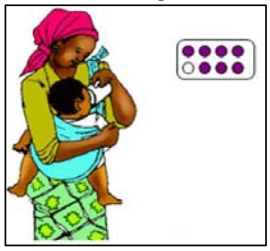
One of the reasons we believe the Care Group methodology has been so effective in reducing malnutrition is that non-literate mothers can remember and communicate key messages using images to jog their memory. To test this theory, three images were selected from 5 CG flipcharts the project used and shown to LM and BM. The LM and BM were asked to state the complete key messages.



The first image LM and BM were shown can be seen above. The message this image is intended to convey is that diarrhea for more than two weeks is an emergency. Only 17% of LM and 33% of BM were able to correctly state the complete message. About a third of LM incorrectly associated this image with "diarrhea with blood" or "dysentery". The other third stated that diarrhea was an emergency but left out "for ten days".



CG participants did better at identifying the next two images. The key image associated with the image to the left is that "breastfeeding prevents malnutrition and other illnesses". 66% of LM and both Phase I & II participants could correctly state this key message. The 3rd image was meant to convey that children 12m of age should take de-worming medicine every six months. 65% of LM and 65% of BM were able to correctly state this key message.



Even as CS staff participating in the workshop reviewed these images it became clear that the images themselves were unclear, confusing, or lacked symbols to indicate aspects of the key message. The CS project tested images in the nearby project district of Manga before printing each flipchart, but these results indicate that additional effort and time should be taken to ensure images are easily understood by participants. It was also suggested that more time be taken during the CG meetings to ensure the LM remembers the complete key message. When officials supervise Promoters and LMs, their supervision checklist instructs them to check key message association with images, it appears more care needs to be taken in the supervision process to assure the correct and complete communication of messages.

H. Care Group interaction with Community Leaders

1. Conflict Resolution by Community Leaders

65% of Promoters said that one way that Community Leaders participate in the project is to collaborate on conflict resolution. We asked the participants what sort of conflicts come up at the community level, how CLs help resolve these conflicts, and how to prevent the more common conflicts. Participants mentioned:

a. Sometimes there is **jealousy related to political party affiliation** since Leader Mothers are often from different parties. LMs do not use their influence to talk politics with the families that they serve, but some people in the community are suspicious about that happening. In Manga, during party campaigns, the secretary for the area asked FH to stop Care Group meetings for the 45 day campaign period. FH presented to the Mayor concerning this, and he relented. In the end, FH stopped teaching for two weeks rather than 6 weeks.

b. **Some beneficiary mothers think that the LMs get paid**, and make trouble concerning that. The CLs have intervened to clarify that to the community.

c. Sometimes the LMs go directly to the CLs to ask for help with conflicts, such as when there their **husbands are jealous and do not want LMs to attend the CG sessions**. In these cases, the CLs intervene by inviting the husband to sit down and talk.

d. There are also some **political and religious conflicts** amongst people that affect the project because there are some sects that do not allow wives to participate in sessions. In these cases, the CLs invites the husband to talk and explains the benefits to them of participation.

e. There have been some **conflicts concerning incentives**. CLs intervene to explain why some mothers (Leader Mothers) get the wrap-around skirt once every two years and others (beneficiary mothers) do not, and why Promoters get bicycles. They explain the project objectives and why Promoters and LMs get those things early in the project to minimize that as a problem, but some conflicts still come up.

f. **Social conflicts like divorce** are also a problem at times. Some LMs and beneficiary mothers abandon the program due to divorce. CLs try to intervene sometimes to help prevent divorce. CLs intervene in cases of pending divorce with the community courts which are charged with handling this. If the dispute cannot be handled locally, it goes up the chain of command. This conflict resolution helps the project because the mother can remain in the community if she is not divorced (rather than going back to her family of origin). Participants' impression (and interpretation of the data) is that Leader Mothers are less likely to divorce now because of the program. 61% of LMs said that there husbands respect them more now since they began volunteering as a LM.

g. **Land conflicts** also affect the program. Land conflicts lead to the migration problem that makes some LMs drop out. CLs intervene in these cases by determining who the actual owner is, and to find the LM other land where she can live if she does not have title to where she is living and there's a conflict.

h. **Cultural conflicts** affect the program. The project staff and volunteers urge people to use the MOH health centers vs. traditional medicine (especially witch doctors), but people continue to use it. CLs intervene by talking to people about the advantages of giving MOH medicines instead of traditional medicines. (There's a difference between traditional medicine [witchcraft] and proven, dosed, natural medicine [which FH sometimes promotes].

2. Public Recognition of Leader Mothers

Knowing that public recognition is one important way that CLs can motivate and incentivize the Leader Mothers and Promoters work, we asked the participants what was done in this regard. Participants said that **CLs do some public recognition of the Promoter and Leader Mothers** during public community meetings. They will invite the Promoter or LM to come and do a session so that the people will know him or her better. During that session, they will say positive things about the Promoter, especially talking about the changes they have seen in the community as result of the Promoters' and LM's work, and thanking them. When there's an epidemic, CLs look for Promoters to do health promotion, and Promoters consider this a form of recognition. Promoters are asked to do this more often than LMs. It is not common for these CLs to give awards or prizes for community service. It would help to teach CLs about doing this as a way to motivate their LMs and Promoters.

3. Establishing Local Community Norms and Advocacy for Mothers

18% of Promoters said that Community Leaders (CLs) helped the project by putting in place community norms that urge families to adopt behaviors promoted by the project. Participants said that these are community norms like asking telling all community members that they are now to use bleach to purify all drinking water in the community. There are no fines for going against the norm. However, there are sometime penalties, and occasionally they are harsh. For example, some CLs have told people that if they did not have a latrine, they would have to leave the community. Also, sometimes community members will refuse to help a family because they did not take on the preventive practice (e.g., not helping a family with a child with diarrhea because they did not construct a hand washing station). CLs sometimes believe that suffering the consequences of these decisions will lead to behavior change.

Participants said that it happens fairly frequently that they health facility staff will also withhold services to families that do not participate in the preventive practices. For example, if a mother does not give birth in hospital, they will not give her the child's growth card, and the family will have to go through a series of bureaucratic steps or do extra work (plowing a community garden) in order to get the growth chart for the child. Ethics aside, this appears to be supportive of behavior change. **However, while the CLs promote these strict practices, the Promoters do not support them, and sometimes (rightly) work actively against them.** Promoters are worried about some of these practices. For example, if a mother has a home delivery, the health facility staff will sometimes give her poor care afterwards, and the Promoters have had to advocate for these women to get better treatment.

I. **Behavior Change Theory**

When asked Promoters about what keeps mothers from changing (during the focus groups and this KPC), and **there was little mention of the eight determinants mentioned in Barrier Analysis** (BA, which is based on the Health Belief and Theory of Planned Behavior models). Promoters were less likely (10%) to attribute lack of behavior change to "social-economic level and culture" than Leader Mothers (21%), but it still appears that many Promoters have not changed their thinking about what helps and hinders people from changing. When we asked what could help change that situation, participants (especially management staff) said that **doing the full Designing for Behavior Change workshop with all Promoters** would be helpful (which includes Barrier Analysis). Only 17% of Promoters participated in the two-day BA training. Also, the CS Program Manager said that **alternative terms needed to be used for the determinants** (e.g., "perceived self-efficacy") when working with Promoters (some of whom only have a 7th grade education). The "Fisherman Story" in the BA training was helpful, but even the Promoters who had the BA training needed more exercises (e.g., the **scenario cards** used by FH in Burundi) to help them identify barriers properly. **One page handouts on the findings from BA** (for each behavior studied) should be created, as well.

J. Interactions with MOH Clinical Staff

1. Promoter communication with health facility staff

About half (47.%) of Promoters claimed to have visited MOH health facilities as part of their work four or more times during the past 12 months (quarterly or more often). We asked the participants what was discussed during these meetings, what data was exchanged, and what could be done to strengthen the relationship between the Promoters and health facility staff:

a. **Promoters talk to HF staff about diarrhea cases and epidemics**.
b. **Promoters help with health promotion at the HF**, working with the people in the waiting area. Some Promoters do this health promotion weekly, but others are too far from the HF to do this. Participants disagreed as to whether all Promoters could do this weekly teaching (in addition to working with the Care Groups, IMCI-trained LMs, etc.), but agree that they could have Promoters do health promotion at the HF when they live within X (yet undetermined) kilometers of the health facility. Other Promoters who were further away could do alternative activities like community-level health promotion meetings and participation at the mobile posts.
c. **Promoters take information from the HF to the community regarding campaigns** (for immunization, Vitamin A, and deworming) and outreach posts. Prenatal consults, health promotion and GM/P are also done during these monthly or bimonthly outreach posts.
d. **No logistical support is provided by FH to the MOH for these posts, but Promoters and LMs help through community mobilization.** LMs and Promoters help directly in these posts by dosing polio vaccine, vitamin A, and mebendazole to children, and doing GM/P, MUAC, and health promotion. (Promoters learned how to do GM/P during the Hearth training.) Project staff believe this has led to large increases in care seeking and participation in mobile posts.

e. To strengthen this relationship, participants said that **Promoters should report out monthly directly to the HF staff on their activities in addition to reporting out to the MOH at the district level monthly meetings**.

2. Referrals by C-IMCI LMs and Promoters

Promoters and C-IMCI trained LMs refer cases to the health facilities using referral cards. Promoters follow-up at the health facility (during their meetings with HF staff) to find out if referred patients showed up. If nurse is too busy to see a patient (and sends them home), the Promoter will sometimes go and advocate for the patient to make sure they get in. The mother receives the referral card from either the C-IMCI trained LM or Promoter, takes it to the HF, and the HF staff write on the back of the card. (C-IMCI trained LMs do the majority of the referrals.) The mother then is responsible for bringing the card back to the C-IMCI trained LM or Promoter, and the Promoter reports that data in their monthly report. The C-IMCI trained LMs are trained to do follow-up with the mother, as well. Even if the HF staff does not write on the back of the card, the LM will verify if the mother received medications and ask about the visit. When the C-IMCI LM follows-up, she collects the referral card and turns them in to the Promoter.

Participants said that there are fewer mothers now who go to the C-IMCI LMs than earlier in the project because more mothers know the child danger signs, and they choose bypass the LM and go directly to the HF (since the C-IMCI trained LM does not have medications, does not do CCM, etc).

The CS Program Manager changed the strategy somewhat recently. **FH now trains the Promoters in C-IMCI, and the Promoters then train <u>all</u> of the LMs on the C-IMCI protocols so that all of them have the training.** All LMs have the C-IMCI protocols laminated sheets. Some nurses at HFs (especially ones recently transferred to the area) sometimes refuse to accept referrals from the LMs because the nurses were not trained in IMCI by FH. The Health Officials (FH) do talk to new staff to explain the system to them. However, FH management feels that there's no need to train these nurses since most of them have already been trained in IMCI by the MOH. (The FH training comes with a per diem.) Each district medical officer (chief) knows about what FH is doing, understands the referral card system, etc., and when there's a problem, they talk to the District medical officer.

Participants agreed that the pictures in the MOH IMCI protocols are far too small, making it hard to see what is happening in each picture, and thus not as useful to LMs as they could be. However, they pointed out that the messages are familiar, and LMs have worked with FH's flipcharts which have larger and better images, so it's not as necessary to advocate for improvements in these laminated sheets.

Since not all Promoters meet with HF staff to discuss referrals, it was suggested that this become a standard part of the Promoters job description. Promoters should also get information on how many cases of different diseases the HF staff are seeing so that they can better understand the local epidemiology. **A standard agenda should be created** for this monthly meeting.

To strengthen the relationship with the HF, **FH could help more with logistics** (e.g., vehicle use). Otherwise staff feel that they will continue to sometimes face discrimination by the MOH and be "put aside." **They felt that providing more logistical support to the FH would lead to more receiving more respect from the MOH.**

K. Phase I Review

Promoters in Phase I have been going through a second round of the lesson plans covered in the first half of the project in order to review them. Leader Mothers in Phase I continue to reach new mothers as they are identified (e.g., new pregnancies). We asked participants if there was any problem with doing this review, if it was interesting for Leader Mothers, and any changes that they would recommend for the future. Participants said that revision needs to happen, but they suggest **a shorter lesson plan** be used for the review. **New songs and games** could be used during the review while keeping the same key messages. It would help, also, to **look at the mini-KPC data, do more Barrier Analysis on indicators that have not increased enough, and concentrate more on those lesson plans and messages**. Lesson plans for those key messages associated with indicators that have not increased enough could be modified accordingly (using BA results). Participants felt that meetings with LMs during the review phase continue at the same frequency (every other week rather than monthly). The CS Program Manager, however, felt that once a month would be better and have Promoters implement other activities with the extra time.

ANNEX 1: Focus Group Discussion Guides and Consolidated Responses

Focus Group Discussion Guides for

Care Group Operations Research

FH/Mozambique

Written August 17, 2009 by Tom Davis, MPH, Director of Health Programs, International Programs Department. Translated by Cecilia Lopes.

Results consolidated by Cecilia Lopes and sent to FH office in March 2010

Results translated by Carolyn Wetzel, March 2010.

Objectives

I. Determine through FGDs with Promoters:

a. frequency of meetings
b. teaching aids design, language, and ease of use
c. educational/literacy level of Leader Mothers
d. support from community leaders
e. Use of Barrier Analysis / Doer-NonDoer Analysis findings
f. Identify motivating factors and disincentives that affect Care Group participation by Leader Mothers and behavior change adoption of beneficiary mothers
g. Use of Verbal Autopsy results
h. Assess what changes Promoters believe they have made (e.g., confidence, skills) with participation in the Care Group program.
i. Assess what changes Promoters believe Leader Mothers have made (e.g., confidence, skills) with participation in the Care Group program.
j. Assess what changes Promoters believe Leader Mothers have made in terms of their relationships with spouses, other family members, others in the community, and God.
k. (In interview with best Promoters as identified by Officials: Identify characteristics of a good CG promoters and supervisors.)
l. Assess retention of Leader Mothers factors associated with high retention.

II. Determine through FGDs by Officials with the Leader Mothers

a. how groups are formed (elected or appointed Leader Mothers)
b. frequency of meetings
c. beneficiary teaching methods (group or individual home visits), length of lesson, use of teaching aids, didactic or participatory
d. teaching aids design, language, and ease of use
e. educational/literacy level of Leader Mothers
f. use of Barrier Analysis / Doer-NonDoer Analysis findings
g. Identify motivating factors and disincentives that affect Care Group participation by Leader Mothers Identify what Leader Mothers consider to be key factors in adoption of new behaviors (by beneficiary mothers) promoted via CG education.
h. Assess what changes Leader Mothers believe they have seen in themselves (e.g., confidence, skills) that are associated with participation in the Care Group program.
i. Assess what changes Leader Mothers believe they have made in terms of their relationships with spouses, other family members, others in the community, and God.
j. Assess what changes Leader Mothers believe the beneficiary mothers have made (e.g., confidence, skills) that are associated with participation in the Care Group program.
k. Assess what changes Leader Mothers believe the beneficiary mothers have made in terms of their relationships with spouses, other family members, others in the community, and God.
l. Characteristics of good CG promoters: What they like best and least, etc., about their Promoter. Opportunities for improvement.
m. Assess retention of Leader Mothers and factors associated with high retention.

III. <u>Determine through FGDs by Officials with Beneficiary Mothers</u>

a. how groups are formed (elected or appointed Leader Mothers)
b. frequency of meetings / contact with LMs
c. beneficiary teaching methods (group or individual home visits), length of lesson, use of teaching aids, didactic or participatory
d. Identify motivating factors and disincentives that affect behavior change adoption of beneficiary mothers
e. Assess what changes Beneficiary Mothers believe they have seen in themselves in terms of confidence and skills that are associated with participation in the Care Group program.
f. Assess what changes Beneficiary Mothers believe they have made in terms of their relationships with spouses, other family members, others in the community, and God.
g. Assess in what ways Beneficiary Mothers believe that Leader Mothers have changed as a result of their working with the Beneficiary Mothers in terms of confidence and skills.
h. Assess in what ways Beneficiary Mothers believe that Leader Mothers have changed as a result of their working with the Beneficiary Mothers in terms of relationship with others and relationship with God.

IV. <u>Determine through FGDs with Community Leaders</u>

a. training/involvement of community leadership
b. support from community leaders
c. Identify motivating factors and disincentives that affect behavior change adoption of beneficiary mothers

d. Identify motivating factors and disincentives that affect behavior change adoption of beneficiary mothers
e. Knowledge and use of VA results

V. <u>Determine through FGDs with CG Participants in former DAP II Areas</u>

a. Follow-up with past Care Group participants (from the DAPII project) who have stopped participating in organization-led activities for at least 12 months. Determine the level of activity that CGs have maintained, the level of behavior change that has been sustained, and factors that have motivated or served as incentives and disincentives for continued participation in CG after the organization's departure.

VI. <u>Determine through FGDs with Health Facility Personnel in areas where CGs were active 2006-2008</u>

a. Knowledge and use of the Care Group structure and process, and opinions on effectiveness
b. Knowledge and use of VA results
c. Changes seen over the past few years in terms of mother's health behaviors, use of health facilities (see data).

VII. <u>Determine with Health Facility Personnel in areas where CGs were not active 2006-2008</u>

a. Changes seen over the past few years in terms of mother's health behaviors, use of health facilities. [We have provided a brief FGD guide, but it may not be necessary. For this objective, look at health service utilization data. Consider doing a mini-KPC in these communities and examine key indicators + weight-for-age.]

VIII. <u>Determine with in-depth Interviews with Officials:</u>

a. Identify characteristics of a good CG promoters and supervisors. [No guide was created for this objective. Just meet with Officials and have them brainstorm characteristics of good Care Group Promoters and Supervisors. Have them reflect on which ones served for the most time, and ask them to discuss why they think these Promoters and Supervisors stayed in the project for longer.]

Other objectives & comments:

1. Compare the cost-effectiveness in reducing child mortality of CGs that target pregnant women or mothers with children <2 years of age vs. those that include all households. [This should be done through a comparison using the Bellagio Lives Saved Calculator and calculating cost per life saved in WR, FH, and other programs that use Care Groups. See if Curamericas/ Guatemala would be willing to use the calculator.]
2. Assess retention of Leader Mothers and Promoters and factors associated with high retention. [See if there are records on this, or a way to reconstruct it to get at amount of turnover.]
3. Assess usage of C-IMCI-trained Leader Mothers. [Do record review to determine the usage rate. Consider putting in a question on this in next mini-KPC in Phase I communities. Review QIVC scores for IMCI, as well.]

4. Document CG impact on facility-based service utilization comparing MOH facility data from regions where CG were active and where they were not. [Update graphs that Don developed during the midterm evaluation, or just use those in the report.]
5. Document the estimated lives saved and cost of lives saved due to the MCH interventions of projects using CGs. [Use Bellagio LSCs that we already have for FH and WR with permission. Ask Curamericas and other orgs to submit theirs.]

I. Focus Group Guide for Use with Child Survival Promoters (FH/Mozambique CS Project)

Participants: It would be best to draw all of the Promoters in one district to form a focus group. This should be done in each district.

Introduction: *The purpose of these discussions is for Food for the Hungry, the Ministry of Health of Mozambique and other partners to better understand how FH's Care Group project was carried out and what changes have come about as a result of the project. There are no right or wrong answers to the questions that we will discuss. You should feel free to agree or disagree with others in the group as everyone is entitled to their opinion. Rather than trying to reach a consensus of the group, we want to hear the different ideas that each of you have concerning the questions we have, and we hope that you will all feel comfortable sharing what you think. After we ask each question, we will repeat it to assure you know what we are asking. After that, anyone can respond, agree, disagree, add their comments, etc. We do not want to go around the circle and have each person respond. Instead, we want the group to discuss the question.*

Note: For each question, read the question in its entirety and then repeat it so Promoters can think about it. Read all of the questions in each question together as you want promoters to discuss the subject and not each respond to each specific answer. If in their discussion, they do not respond to each question, after the discussion you can repeat part of the question that they did not answer.

1. First of all, we would like to have you talk about **some of the ways in which the Care Groups were organized and worked in the communities that you served**.
   a. **How often did you meet with each Care Groups?** Was it always every other week, or were there times when you had to meet more or less frequently?

      - **2 lessons a month are given, this includes the day of the lesson and a day to so follow-up through home visits with the mother's who missed the lesson.**

      b. What did you think of the **educational modules, the lesson plans and flipcharts that were given to you to teach the Leader Mothers**? Were they easy to use? Were the messages written in such a way that they were easy to communicate to the Leader Mothers? If you got to design the materials yourself or tell someone else how to change them, what would you recommend they change in the flipcharts and lesson plans to make them easier to use or more effective in terms of helping mothers to change?
         - **The topics of the modules are appropriate and applicable to the community.**

- **The flipcharts are very practical and can be easily used by people who also can not read**.
- **Some Districts (Manga) are of the opinion that lesson plan is neither necessary nor applicable**.

Are they are easy to use?

- **They use them easily.**

Are the messages were written in such a way that is easy to communicate with the Leader Mothers?

- **The messages are clear and easy to communicate to the Mothers**.
- **Mothers who can not read easily understand the messages when you explain the figures of the album**.

If you got to design the materials yourself or tell someone else how to change them, what would you recommend they change in the flipcharts and lesson plans to make them easier to use or more effective in terms of helping mothers to change?

- **Some Districts suggest removing the lesson plan**
- **Laminate the flipchart pages like the C-IMCI counseling cards.**

c. **In what ways did you and the Leader Mothers work with community leaders?** What are examples of ways that you worked together that led to positive results? In what ways did community leaders make it easier for mothers to make changes in their practices? Were there any times that community leaders hindered the work that you were doing?

- **Their involvement in some project activities at the community level.**
- **Encouraged mothers to participate in the teaching.**
- **Collaboration in conflict resolution**

What are examples of ways in which they worked together to lead to positive results?

- **When you involve educating mothers this leads to positive results because it ensures the continuity of the project in the community**
- **They helped to clarify aspects of the project to the Mothers**

In what ways did community leaders make it easier for mothers to change their practices?

- **Encouraging mothers to put into practice the teachings received**
- **Encouraged mothers to participate in the teachings**

Was there any times that community leaders hindered the work that you were doing?

- **The Community Leaders did not create obstacles in the work, but they do like to remind us whenever possible that they would like to receive some compensation for the work they do. This attitude can create some agitation.**

2. Let's talk now about the **participation of Leader Mothers in the Care Groups**.
   a. *(Turnover :)* If you took all of the Leader Mothers that you started to work with at the beginning of the project, what proportion of those Leader Mothers are still working as Leader Mothers? What proportion of them left, moved away, or otherwise stopped working as Leader Mothers? What are the reasons why some Leader Mothers stopped participating? Are there certain qualities that a Leader Mother will have that make her more likely to stay in the group? Are there certain qualities that a Leader Mother may have that would make her more likely to drop out of the Care Group?

- **It was difficult to quantify in all districts the proportion of Mother dropouts. However they affirmed that many mothers had moved to other zones and left the project. The turnover of Mothers is frequent and the motives are many, including weak motivation due to lack of incentives.**

What are the reasons why some Leader Mothers stopped participating?

- **Reasons for the withdrawal are moving to other areas (new homes, other farms, other)**
- **Poor motivation as a result of lack of material incentives (they often claim that they are not compensated for the effort they extend).**
- **Too much time spent reviewing topics they already know (said in Phase I districts).**

Are there certain qualities that a Leader Mother will have that make her more likely to stay in the group? There are LM active and responsible. They do the work for the good of the community and not for FH as many think.

- **There are mothers with the ability to communicate and with charisma to awaken the attention of listeners.**

Are there certain qualities that a Leader Mother may have that would make her more likely to drop out of the Care Group?

- **Mothers who show little interest in lessons, are not active, do not contribute in the discussions, they speak little and participate little in the meetings.**

b. Let's talk about ***why*** **Leader Mothers participate or not in the Care Groups and in health promotion to beneficiary mothers**. You have talked to a lot of Leader Mothers. What are the different reasons that Leader Mothers participate in the Care Groups and visit their beneficiary mothers?

- **The spirit of volunteerism to work for the good of the community**
- **Willingness to help others and be useful for community**

What are the different things that motivate them and make them want to continue doing health promotion?

(No Response)

What are the things that make them NOT want to participate in the Care Groups or NOT want to visit beneficiary mothers?

- **The main reason is the nature of the project. Since it's a sustainable project that does not give fish but teaches people how to fish.**
- **The communities have become used to doing things in exchange for compensation.**
- **Do not have the spirit of volunteerism.**
- **Existence of other community development projects that give incentives to people working for them**

c. What is the level of education and literacy level of Leader Mothers? What portion of the Leader Mothers can read most of what is on the flipcharts that are in use?

- **Most of them have primary education**
- **Very few have secondary education**
- **Many of them participate in the literacy program sponsored by the Government**

What proportion of mothers Leaders can read most of the flipcharts in use?

- **Very few mothers can read the albums**
- **Even the mothers who have primary education have difficulty reading**

3. Let's talk now about **why some mothers made healthy changes and others did not**. One of the main objectives of this project was to help mothers to adopt healthier practices so that their children are more likely to survive -- changes in terms of how they care for their children, how they seek care for them, how they feed them, etc. Many mothers that the Leader Mothers visited did change what they were doing, but some did not. For those mothers that did NOT change, what are the reasons that – in your opinion – they did not change? For those mothers that DID change, why did they change?

- **Mothers are still resistant to change**
- **Mothers are still very connected to culture, tradition and customs**

For those mothers that DID change, why did they change?

- **Mothers have changed because they felt that the change was important, necessary and beneficial**
- **Mothers have changed because they have been made aware of good practices, they didn't adopt the good practices before only because they lacked the information. Mothers have changed because they are concerned about the welfare of their family**

4. Now we want to talk about **other changes that you have seen as a result of this project**:

a. **What changes have you seen in yourself** as a results of participating in this project and working with the Care Groups?

- Have you changed in terms of the things that you do or know how to do? What changes?

- **The way of being and acting in the community has changed.**
- **Changed the way they do things because they also learned and adopted healthy practices that they are implementing**
- **There was also a need to change behavior on behalf of the Organization [FH] and in order to be accepted and respected by the community**

- Have you changed in terms of how you feel about yourself? What changes?

- **They feel more capable to teach and confident in what they do.**
- **Acquired communication skills**
- **Acquired skills to produce reports, analyze data and interpret data.**
- **Acquired skills to do surveys**

- Have you changed in terms of how you interact with your family members, community members or community leaders? What changes?

- **Promoters say they have learned to listen and respect the various opinions**

- Have you changed in terms of your religious beliefs or practices, or how you experience God? What changes?

- **They seek to have God always present in what they do**
- **Most Promoters said that already related to God and the work with FH has served to strengthen the relationship**

b. **What sort of changes do you believe the Leader Mothers have made** as a result of their participating in the Care Groups and visiting the mothers and pregnant women in their communities?

- **ML are able to deal with health problems in the community**
- **ML adopted good practices of hygiene, sanitation, and nutrition**
- **ML follow up on the pregnant and newborn infants in the community (in Phase I Districts)**

- Have the Leader Mothers changed in terms of the things that they do or know how to do? What changes?

- **Some ML has changed and do things according to the lessons learned**
- **Know what to do and how to face certain situations**

- Have the Leader Mothers changed in terms of how they feel about themselves? What changes?

- **They feel more empowered and safe in carrying out activities**

- Have the Leader Mothers changed in terms of how they interact with their family members, their neighbors, or community leaders? What changes?

- **The relationship with the family, neighbors and leaders is good**
- **The community in general trusts and seeks advice from the Mothers.**

- Are there any changes in their religious beliefs or practices, or how they experience God?

- **There are mothers who have changed their beliefs and practices**
- **There are others that are still linked to false beliefs and practices**
- **Still others relate to God but also believe in healers and prophets, which interferes in the process of decision making and behavior change**

5. There were a few tools that we used in the project to help understand what needed to change to help children survive and how to help mothers to make those changes.

   a. What are the things that you learned from the **Barrier Analysis studies** that we did in project communities? In what ways did the information from those studies influence the things that you taught to the Leader Mothers or the ways that the Leader Mothers tried to convince mothers and pregnant women to make changes in their practices? Did you find those studies helpful in helping mothers to make changes? In what way?

   - **Promoters say they have learned that within the same community there are mothers who adopt healthy practices in the care of their children and others who do not**
   - **They learned that what makes some mothers not adopt practices is the lack of knowledge, taboos, culture and tradition.**

   In what ways does information from these studies influenced the things you taught to mother's leaders or how the Mothers leaders tried to convince the mothers and pregnant women to bring about changes in their practices?

   - **The lessons learned from these studies influenced the way we dealt with the topics in the CG. We already knew the perceptions of the Mothers in relation to determined questions and this helped.**

   They think that these studies were useful in helping mothers to bring about changes? How?

   - **Were useful**
   - **Non-doer Mothers were encouraged to follow the example of practitioners (doers).**

   b. What are the things that you learned from the **Verbal Autopsies** that you conducted in some project communities? In what ways did the information from those autopsies influence the things that you taught to the Leader Mothers or the ways that the Leader Mothers tried to convince mothers and pregnant women to make changes in their practices? Did you find those autopsies helpful in helping mothers to make changes? In what way?

   - **Promoters say they know what the probable cause of death of children in the community is.**

- **They also learned that despite the teachings of the CG are still mothers who spend their time looking for the prophets and healers when children get sick**
- **That there is still delay in going to the health post in case of illness because of the financial factor (money for transportation and accommodation) and the distances**

Separate activity:

Interview the best Promoters (e.g., top 1-3 in a district as identified by the Officials), and try to determine what makes them so good at what they do. Talk to them about their work, their motivations, and look for – and ask about – special characteristics they have, charisma, knowledge, teaching skills, motivations, work ethic, background, etc. Do the same for Officials.

II. Focus Group Guide for Use with Leader Mothers (FH/Mozambique CS Project)

Participants: It would be best to draw Leader Mothers from different Care Groups to form each of these focus groups (e.g., 2-3 Leader Mothers from 4-5 Care Groups to form one focus group).

Introduction: *The purpose of these discussions is for Food for the Hungry, the Ministry of Health of Mozambique and other partners to better understand how FH's Care Group project was carried out and what changes have come about as a result of the project. There are no right or wrong answers to the questions that we will discuss. You should feel free to agree or disagree with others in the group as everyone is entitled to their opinion. Rather than trying to reach a consensus of the group, we want to hear the different ideas that each of you have concerning the questions we have, and we hope that you will all feel comfortable sharing what you think. After we ask each question, we will repeat it to assure you know what we are asking. After that, anyone can respond, agree, disagree, add their comments, etc. We do not want to go around the circle and have each person respond. Instead, we want the group to discuss the question.*

Note: For each question, read all of the questions listed for each letter (e.g., "a.") completely and then repeat them so mothers can think about them. It is important to read all of the questions in each question together as you want Leader Mothers to discuss the subject and not each respond to each specific question. If in their discussion, no one responds to a particular question, after the discussion you can "probe", repeating part of the question that they did not answer.

1. First of all, we would like to have you talk about **some of the ways in which the Care Groups were organized and worked in your communities**.

   a. **How were you and the other Leader Mothers in your Care Group chosen?** Were you elected by the mothers that you serve, elected by community leaders, or chosen in some other way?

   - **They were invited by Community Leaders or Promoters to be part of the FH Project**
   - **A census was done, registering all pregnant women and women with children 0-23m, then MB CG's were formed, and each MB CG elected one ML.**

   b. How many of the mothers in your group are **able to read well**? How many are able to read a little? Was it very hard for mothers who cannot read at all to use the flipcharts?

- **It was difficult to quantify in all the districts where the study was conducted the number of Mothers who know who to read correctly.**
- **The answers were too vague, such as "some women know how to read."**

c. **How often did your Care Group meet?** Was it always every other week, or were there times when you met less frequently?

- **Care Group meetings happened every 2 times per month. Two lessons per month.**

d. **How many of the Leader Mothers in your group dropped out of the Care Group during the life of this project?** What do you think the reasons are that they dropped out? What type of Leader Mothers are more likely to stay in the group?

- **Difficult to quantify**
- **Motives of drop-out: relocation to other houses, farms, or other motives.**

2. Let's talk about **Promoters**:

a. Please keep in mind that everything you say is confidential and will not be shared with the Promoters. **What was the relationship like between you and your promoter?** What did you like most about the way that the Promoter worked with you and your Care Group? What did you like least? What could have the Promoters done to work more easily with your group? In what ways could they improve?

- **We liked the promoters work. The promoters were attentive, patient, and persistent during the teachings.**
- **We liked the home visits and follow-up the promoters do with there is a sickness in the beneficiary's family.**

3. Let's talk now about the teaching methods that you used.

a. What did you think of the **teaching done by the Promoters in your group**? Was it easy to understand? Were the lessons boring or interesting? If you got to design the training yourself or tell someone else how to do it, what would you recommend they change in the lessons the Promoters taught to make them more effective in preparing you for your volunteer work as a Leader Mother?

- **Teachings are easy to understand.**
- **The use of visual images and questions to verify understanding keep the meetings dynamic.**
- **Classes are not tiring due to the use of a participatory methodology (everyone talks), which includes discussions.**

b. What about the **flipcharts** that were given to you to use with mothers? Were they easy to use and understand? Were there particular ones that were difficult to use? If you got to design the flipcharts yourself or tell someone else how to do it, what would you recommend they change in the flipcharts?

Flipcharts are well understood. The figures are clear and allow easy comprehension even for those mothers who can not read.

c. When you met with Leader Mothers, **did you usually meet with them in groups, or through individual home visits**? (Try to find out what percentage of their contacts with beneficiary mothers were in each type of setting – group or individual.)

- **ML teach their beneficiaries in groups.**
- **For those mothers who were absent in the group meeting, education is given to household**.

d. We know that you are busy and have other activities to do in addition to the teaching you do with beneficiary mothers. **What was the average amount of time that you spent teaching leader mothers during each contact with them in their homes? What was the average amount of time that you spent teaching leader mothers when you met with them in a group?** (NOTE: This is not the Care Group meeting when the Leader Mothers meet together.)

- **A meeting at the home of MB takes on average 45 minutes to 1 hour of time**
- **The meetings of the MB group has lasted approximately 1:30 minutes due to the process of questions, answer, debate, planning the next teaching**

e. There are different ways to convince someone to change their practices or adopt new practices. **What sort of methods did you use to convince the beneficiary mothers to change their practices or to adopt new healthy practices?** Did you just tell them the messages on the flipchart? Or did you discuss the practices with them? Did you demonstrate what you were teaching? What are the different ways in which you tried to convince mothers to adopt new healthy practices (like exclusive breastfeeding)?

- **Teachings of topics related to good practices**
- **Debates on lesson topics**
- **Telling stories of success to related topics**
- **Involvement of LM in the dissemination of messaging and adoption of practices**

f. During this project, we compared mothers who were doing a particular practice with those who were not in something we called **Barrier Analysis studies.** Tell me what you know about that. Did you learn about the results of those studies? How did you use the results in your work as volunteers?

In all districts the BA study is known to identify the reasons that prevent some mothers in the community to adopt some practices that are beneficial to them and their families

- **They learned that in the same community there are mothers who adopt good practices for child care and others who do not.**
- **They learned that some mothers in the community have been able to maintain a healthy family and that others can do so as well.**
- **They learned that the lack of information, the customs and culture prevent mothers from adopting good practices**

- **The results of BA studies are used as examples in the GC to help in changing attitudes and behaviors.**

g. What were the main messages that you promoted to get mothers to exclusively breastfeed?

- **Key messages promoted spoke of the benefits of giving only breast milk until the child was six months old.**
- **Breast milk is best for the baby**
- **Breast milk has everything the baby needs to protect against disease**.

How did you convince them to do that?

- **Teaching topics related to exclusive breastfeeding by using the album series**
- **Creating the CG debates on the subject**
- **Using the testimony of mothers within the GC that had already adopted this practice**
- **Using examples where possible comparing mothers practitioners and non-practicing.**

h. Most Leader Mothers attended the Care Group meetings, but some Leader Mothers attended more than others. **What do you think are the reasons why some Leader Mothers hardly ever missed a meeting and others missed meetings more often?**

- **Work on farms to feed the family**
- **Mothers prioritized paid work on their farm**
- **Low motivation of some mothers due to lack of incentives from the project when compared with other community development projects.**
- **Resistance to change in mentality regarding the issue of sustainability of the project. There are also mothers who are motivated to do things according to material compensations (soap, soy, Cash transfers, etc.) and are used to receiving these projects compensations.**

i. Most beneficiary mothers learned some things from Leader Mothers, but some beneficiary mothers put more of what they learned into practice than others. **What do you think are the reasons why some mothers adopted more of the healthy practices than other mothers?** For mothers who did not adopt many of the practices, why do you think they did not? Was it due to their way of thinking, pressure from families members not to adopt the healthy practices, not thinking it would be good for their child, or other reasons?

- **Social, economic and cultural level of Mothers**
- **There are families within the community that has access to information from the radio / TV, those families have a different way of perceiving things and are less resistant to change**
- **There are also wives of nurses and teachers, who are open to dialogue and therefore are within the family an incentive to change**
- **There are mothers who have had the opportunity of attending school (basic education) or have worked as activists in other organizations so you are more open-minded.**
- **Still very bonded to culture and traditions, taboos and religious beliefs.**
- **They do not find within their household that there is an incentive to change.**

4. Let's talk now about the involvement of other community leaders and continuation of your work:

a. **In what ways did you work with community leaders during this project?** What are examples of ways that you worked together that led to positive results? In what ways did community leaders make it easier for mothers to make changes in their practices? Were there any times that community leaders hindered the work that you were doing?

- **Involvement in the identification of young people in the community to work with FH**
- **Involvement in the mobilization of mothers to be part of the project**
- **Involvement in spreading information on objectives and importance of the project**
- **Collaborate in the process of conflict resolution to the level of benefits from the project**
- **Involvement in awareness of Mothers to participate in teaching**
- **Involved in the mobilization of mothers to seek health care in the health post.**

What are the examples of the ways they work together, leading to positive results?

- **When there are vaccination campaigns the promoters and community leaders mobilize mothers to join the campaign and clarify the benefits. They are present at the campaign and collaborate in the organizing the mother's participation.**
- **When there are visits from project personnel the CL assure the information arrives to the community and participate in organizing the reception of visitors.**
- **In the case of low participation in the teachings or beneficiary discontentment then the CL has an important role to overcome the situation**.

In what ways community leaders make it easier for mothers to bring about changes in their practices?

- **Encouraging mothers to put into practice the lessons learned**

Are times when community leaders pose obstacles to the work they are doing?

- **The LC does not create obstacles or interfere with the work.**

b. **As you know, this project will end in October 2010. There is no more money after that time to pay Promoters to visit communities.** In other places where Care Groups have been used in Mozambique, the mothers decided to continue to visit mothers of young children so that they could continue to help mothers to have children that survive and grow healthy. When Leader Mothers dropped out, the community selected new Leader Mothers to replace them and trained them. Do you believe the Leader Mothers in your group will continue to visit mothers after FH pulls out? Are there things that the Ministry of Health could do to make that easier for Leader Mothers? If some Leader Mothers drop out, do you think that the other Leader Mothers would be willing to train new Leader Mothers?

- **The visits will continue, the knowledge will continue to be shared with neighbors and friends within the community**

Are there things that the Ministry of Health could do to make that easier for Leader Mothers?

- **No answer given in all districts.**

If some Leader Mothers drop out, do you think that the other Leader Mothers would be willing to train new Leader Mothers?

- **The ML can transmit the knowledge acquired to the other Mothers of the community to do the same job with their nearest neighbors**.

5. **To close, let's talk about some of the changes that you have experienced by participating in the Care Groups and this project.**

   a. We have heard that some Leader Mothers believe that they have **seen changes in themselves during this project in terms of what they do, how they think, how they see themselves, their skills, or in some other way**. What are the ways in which you have changed as a result of participating in this project? What new skills do you have now? What do you do differently? How do you see yourself or feel about yourself differently?

- **Participation in the project has changed the habits and in some cases the customs in the districts**
- **Adopted good practices of hygiene and sanitation including the use of latrine, trash removal, use of tippy-tap, and washing hands.**
- **Healthy nutrition practices and exclusive breastfeeding were adopted.**

What new skills you have acquired?

- **Ability to give using flipcharts**
- **Ability to give report to promoter.**
- **Ability to identify signs of distress in children and pregnant women and provide appropriate counseling**
- **Ability to practice good hygiene and sanitation and eat healthy food.**
- **Ability to deal with cases of diarrhea in children (how to give ORS, give more fluids, and cool the body)**
- **Ability to properly breastfeed the child (the correct position, emptying both breasts)**
- **Ability to identify when a child is underweight and decide what to do**

What do you do differently?

- **For some changed the way they make decisions in case of illness. They now seek first help at the health post and then the prophet or traditional healer.**
- **For others the way to take care of children when they are sick has changed.**
- **For others personal and home hygiene (the trash is buried, using the latrine and practicing hand washing)**

How do you feel about yourselves and the way they do things?

- **They feel safe and confident to care for children**
- **They feel proud of the fact that the community recognizes their work, trust them and seeks advice from them.**

b. We have also heard that some Leader Mothers feel that their relationships with others or with God has changed as a result of participation in this program. In what ways do you think your relationship your husband or other family members, community leaders, the beneficiary mothers or other neighbors has changed as a result of your participation in this project? If your relationship with God has changed as a result of your participation in this project, in what way has it changed?

- **The relationship is good, the entire community relies on our knowledge, respect us and look to us with confidence**
- **The relationship in the family is good and even some husbands are proud of the work of wives. They are happy when the beneficiaries come to them with their concerns.**

If your relationship with God has changed as a result of your participation in the project, how has it changed?

- **Many of them had a relationship with God prior to the project but the relationship was strengthened through the project and learned to be grateful.**
- **We give thanks before teaching.**
- **We give thanks after teaching.**
- **They thanked the end of education**.
- **Praised God with songs and teachings.**

III. Focus Group Guide for Use with Beneficiary Mothers (FH/Mozambique CS Project)

Participants: It would be best to draw beneficiary mothers from different Care Groups to form each of these focus groups (e.g., 2-3 mothers reached through 4-5 different Care Groups to form one focus group).

Introduction: *The purpose of these discussions is for Food for the Hungry, the Ministry of Health of Mozambique and other partners to better understand how FH's Care Group project was carried out and what changes have come about as a result of the project. There are no right or wrong answers to the questions that we will discuss. You should feel free to agree or disagree with others in the group as everyone is entitled to their opinion. Rather than trying to reach a consensus of the group, we want to hear the different ideas that each of you have concerning the questions we have, and we hope that you will all feel comfortable sharing what you think. After we ask each question, we will repeat it to assure you know what we are asking. After that, anyone can respond, agree, disagree, add their comments, etc. We do not want to go around the circle and have each person respond. Instead, we want the group to discuss the question.*

Note: For each question, read all of the questions listed for each letter (e.g., "a.") completely and then repeat them so mothers can think about them. It is important to read all of the questions in each question together as you want mothers to discuss the subject and not each respond to each specific question. If in their discussion, no one responds to a particular question, after the discussion you can "probe", repeating part of the question that they did not answer.

1. First of all, we would like to have you talk about the Leader Mothers that worked with you and how they worked with you.
   a. **Tell us about your visits with the Leader Mothers. When the Leader Mother saw you to teach, did they usually meet with you in a group of other mothers, or come to your home to teach you?** Did they usually come every two weeks, every month, or less often?

      - **Mothers who were neighbors had meetings together**
      - **Mothers who lived far away received individual teaching in their homes**

b. **How often to Leader Mothers just meet with you, and how often did they meet with you and other members in your family** (e.g., your mother, husband, mother-in-law)? Who else usually listened to the lessons?

- **The meetings took place 2 times per Month**
- **Only MB participated in the teaching meetings**
- **The rest of the family was not involved**

c. **How long did the Leader Mother usually meet with you when they visited you in your home? If the Leader Mother met with you in a group, how long were those meetings usually?**

- **The group meetings typically lasted 1 hour / 1 hour and 30 minutes**
- **Visits to the homes of MB for education lasted about 1 hour**

2. Let's talk now about the ways the Leader Mothers taught you and help you to change what you do with your child:

a. **What sort of methods** did the Leader Mothers use when they either met with you in a group or came to your house to teach you about health? How did they teach you? What materials did they use when they met with you? Describe what they would do when they came to visit you.

Group Meeting:

- **The MBs sat in a circle**
    - **The lesson was given by using the flipchart**
    - **The Mother hosting the meeting would give time to talk about families and farms**
    - **A revision of the previous lesson was made.**
    - **Questions related to the day's topic and the pictures in the album were made before starting to explain the lesson.**
    - **Practical demonstrations were done when the lesson required them (example: Preparing Oral Rehydration Solution using packets.)**
    - **There was time for debate**
    - **There was time for the summary of the lesson done by 1 MB**
    - **There was time to plan the next meeting.**
    - **There was time for prayer**

Private meeting at home Mother:

- **MC sat with MB for teaching**
    - **Time for introductory conversation about family and farms.**
    - **The lesson was given by using the flipchart.**
    - **Review of the previous lesson.**
    - **Questions related to the day's topic and the pictures in the album were made before starting to explain the lesson.**
    - **Practical demonstrations were done when the lesson required them**
    - **Emphasized key messages**
    - **There was time to plan the next meeting**

- **There was time for prayer**

b. Did the Leader Mothers just tell you what was on the flipcharts, or did they do other things when they met with you like demonstrations, asking you questions, or using songs or stories?

- **Demonstrations were done, examples from real life were shared, stories, life experiences and questions.**

c. **Did some of you start using new health practices or change what you were doing based on what the Leader Mother was teaching?** What things did the Leader Mother do that made it easier for you to change your practices or adopt new health practices? Were there things that they did that persuaded you to try something that was hard?

- **The MC had a latrine at home**
- **They [ML] had their houses clean**
- **Some ML had children that they took for weighing and vaccination**
- **ML had healthy practices, their example served to motivate the beneficiaries.**
- **ML praised "Star mothers" from the group and this motivated the others to also want to be "Star mothers." *(Star mothers was the term the CS program decided to use for "Model Family Mothers" or Mothers who had adopted key hygiene and nutrition behaviors.)***

Were there some things that the Leader Mother promoted that you were not able to do? What were the reasons why you could not do what the Leader Mothers promoted?

- **The ML promoted many good practices of hygiene, sanitation and food**
- **Some mothers had difficulty adopting the nutritional practices recommended when they were pregnant or giving colostrum to babies because their family (principally the in-laws) did not agree with these practices.**
- **The main reason that causes the mothers to not adopt some practices is the resistance and lack of support from their family.**

3. To close, let's talk about **some of the changes that you have seen during this project**.

a. We have heard that some mothers believe that they have seen changes in themselves during this project in terms of what they do, how they think, how they see themselves, their skills, or in some other way. **What are the ways in which you have changed as a result of being visited by the Leader Mothers and participating in this project? What new skills do you have now?** What do you do differently? How do you see yourself or feel about yourself differently?

- **There was a change in the way of taking care of children, home and family.**
- **Have greater ability to deal with child illness, has the ability to recognize danger signs and act immediately.**
- **Have the ability to make enriched (nutritious) porridges.**

What do you do differently?

- **How we deal with our own and children's illnesses.**
- **Care during pregnancy**

- **How we feed the children and cleaning houses**

How do you see yourself or feel about yourself differently?

- **They feel more secure and capable to care for children**

b. We have also heard that some mothers feel that their relationships with others or with God has changed as a result of participation in this program. In what ways do you think your relationship your husband or other family members, community leaders, Leader Mothers, other mothers, neighbors has changed as a result of your participation in this project? If your relationship with God has changed as a result of your participation in this project, in what way has it changed?

    - **By participating in this project, they have had more contact with the CL. The relationship with the family and other members of the community is good. They say that people in communities generally relate well and are united and it remains so.**

If your relationship with God has changed as a result of your participation in this project, how it changed?

    - **They feel that the relationship with God was strengthened. They learned to put in the hands of God all they do**

c. In what ways do you think the Leader Mother who worked with you changed during this project? Did they talk to you differently now than they did when they first started coming to visit you? Do you think that the Leader Mother's relationship with God has changed during this project? Do they seem more or less confident? Do they seem more or less skilled at what they do?

    - **The LM are respectful and so is their manner of speech. Respect is fundamental in the communities and the ML, being from the community, always knew how to speak well with the beneficiaries.**

Do you think that the Leader Mother's relationship with God has changed during this project?

- **They think that the relationship of ML with God is now more energized**
- **The ML pray in the teachings, and in visits with the families**

Do they seem more or less confident? Do they seem more or less skilled at what they do?

- **They seem more confident and empowered to do their job because they are always trained by the Promoters.**

d. The project will end in October 2010 and the Promoters may not visit the Leader Mothers after that time since there will not be any money. Do you think your relationship with the Leader Mother will change when the project ends? Do you think that they will continue to visit you?

- **Acham que o relacionamento vai continuar a ser bom. They think the relationship will continue to be good. There is friendship between the ML and MB. They share the joys (birth of a child, well-being of the family ...) and the grief (death, illness other problems ...) with one another. Even if the project ends this friendship will remain.**

Do you think that they will continue to visit you?

- **They think that the visits will continue not for teaching purposes but for social reasons. To know how their family and fields are doing and to talk.**

IV. Focus Group Guide for Use with Community Leaders (FH/Mozambique CS Project)

Participants: It would be best to draw community leaders from different communities to form each of focus groups (e.g., 2-3 leaders reached through 4-5 different communities to form one focus group).

Introduction: *The purpose of these discussions is for Food for the Hungry, the Ministry of Health of Mozambique and other partners to better understand how FH's Care Group project was carried out and what changes have come about as a result of the project. There are no right or wrong answers to the questions that we will discuss. You should feel free to agree or disagree with others in the group as everyone is entitled to their opinion. Rather than trying to reach a consensus of the group, we want to hear the different ideas that each of you have concerning the questions we have, and we hope that you will all feel comfortable sharing what you think. After we ask each question, we will repeat it to assure you know what we are asking. After that, anyone can respond, agree, disagree, add their comments, etc. We do not want to go around the circle and have each person respond. Instead, we want the group to discuss the question.*

Note: For each question, read all of the questions listed for each letter (e.g., "a.") completely and then repeat them so leaders can think about them. It is important to read all of the questions in each question together as you want leaders to discuss the subject and not each respond to each specific question. If in their discussion, no one responds to a particular question, after the discussion you can "probe", repeating part of the question that they did not answer.

1. Let's talk first about your training and involvement in this project.
   a. **In what ways were you trained to be part of FH's Care Group project?** What sort of things did you learn from the Promoters and other FH staff about this project and how you could be involved?

      a. There were no training to be part of the project
      b. There was an invitation from FH to work in the community.
      c. It was explained what would be the role of Community Leader in the project context.
      d. We were explained the objectives of the project

      Que tipo de coisas estão aprendendo dos Promotores e do outro pessoal da FH acerca deste projecto e como é que vocês estão sendo envolvidos? What kind of things they are learning from prosecutors and other staff of the FH about this project and how are you guys being involved?

- **We learned from the project that it is time to learn to do things ourselves and not only expect help from others. For this reason FH works in a different way [from other NGOs] in the community by teaching skills such as taking care of children.**
- **We have been involved in the mobilization of the Mothers to teach and attend the teachings.**
- **Resolving problems with the project beneficiaries.**
- **In the vaccination campaigns**
- **Selecting youth from the community to work with the project.**

b. **In what ways were you involved in making changes in your community as part of this Care Group project?** What specific things did you do to help mothers to have healthier children?

- **Encouraging mothers to participate in teaching**
- **Encouraging mothers to practice the teachings**
- **Encouraging mothers to change their behavior**

2. Let's talk now about the effects of this project.

a. Given all of the different projects and work over the years in your community, **how important do you think <u>this</u> project is in terms of reducing child deaths in your community and helping children to be healthier?**

- **They think the project is very important for the health of the mother and child**

  a. **The Health Posts are very far from the communities and the project has activities that meet the needs of the community.**
  b. **If any mother has the child with diarrhea she learned through the project what to do until she can reach the health post.**
  c. **For the cases of malnutrition the mothers know how to identify them and what to do to prevent the child from dying.**
  d. **Mothers know that the health of children depends on her behavior in hygiene, cleanliness, health feeding and growth monitoring (taking the child for consultation).**

b. Do you think this project was effective or ineffective? Why?

- **The project is effective because it has the same concern as the Government that is the health of mother and child and to bring health care to the communities. The project gives response to the needs of the community because the community needs to know how to care for children and not let them die.**

- **The project is effective because it reaches many families. FH teaches ML and then ML teach MB, this enables them to reach a great number of mothers in the community.**
- **Another efficiency of the project is the type of material used for teaching (the flipchart with pictures) that enables the Mothers of the community to teach in the local language, even though most of them cannot read.**

c. **What are the things that the Leader Mothers did that you think helped mothers the most** in terms of changing their health practices and the way that they cared for their children?

- **After giving the teaching the ML passes to visit the houses of the beneficiaries to verify that they are practicing the teaching.**
- **The ML also praised the Beneficiaries when they made changes in behavior and this motivated others to change.**
- **The ML has served them by putting into practice the lessons as a way of motivating change.**

d. **What are the things that <u>hindered</u> mothers the most in making changes that would help their children be healthier and survive?** What sort of barriers did mothers face in terms of doing the things that the Leader Mother suggested?

- **Some do not change because they did not have the support of their family. The family has its culture, religion and customs and it is very difficult to accept some changes that they learned in our teachings.**

e. During this project, we compared mothers who were doing a particular practice with those who were not in something we called **Barrier Analysis studies.** Tell me what you know about that. Did you learn about the results of those studies? How did you use the results in your work as community leaders?

- **Community leaders know little about Analysis of Barriers**

f. During this project and in some communities, we talked to the mothers of children who had died and interviewed them to learn more about the causes of those deaths (**Verbal Autopsies**). Were those verbal autopsies done in your community? If so, are there any things that you learned from those interviews? In what ways did the information from those autopsies influence the things that you did in your community? Did you find those autopsies helpful in helping mothers to make changes? In what ways?

- **They know that the promoters have visited the families when a child dies to present their condolences and learn more about why the child died.**
- **They do not know what the results of these conversations (interviews) were.**

In what ways the information these autopsies influence what they were doing in your community? (No Response)

Do they think that these autopsies are useful to help the mothers to bring about changes? In what ways?

- **They believe that the Promoters, after talking with the families, give some advice to avoid other similar situations**

3. Let's talk now about the sort of changes that you think occurred as a result of this project:

a. We have heard that some leaders believe that they have seen changes in themselves during this project in terms of what they do, how they think, how they see themselves, their skills, or in some other way. **What are the ways in which you have changed as a result of being having this project in your community?** Are there any new skills you have now? Which skills? Are there things that

you do differently? How do you see yourself or feel about yourself differently? Do you think about children differently in any way? If so, in what ways?

They as CL have also learned much.

- **They did not participate in teaching sessions but they had all the information about the activities of the project. After each training FH gave the promoters or the ML they came to the CL to explain the subjects they had learned and what the next step was. They presented the material they received in the training and in this way the CL also learned something.**
- **When they were involved in the campaigns of vaccination and deworming they learned the importance of this for children because these campaigns had lectures on the subject.**
- **Some had the opportunity to participate in meetings called by the project and they say they have learned much about the project and how to take care of a child.**

b. We have also heard that some leaders feel that their relationships with people in their community or with God has changed as a result of participation in this program. **In what ways do you think your relationship with the Leader Mothers or other people in the community has changed as a result of your participation in this project?** If your relationship with God has changed as a result of your participation in this project, in what way has it changed?

- **The relationship with the ML and the community is good and FH being a Christian organization we learned to always put God present in everything we do.**

c. **In what ways do you think the Leader Mother who worked in your community changed during this project?** Did they talk to you differently now than they did when they first began participating in the Care Groups? Do you think that the Leader Mother's relationship with God has changed during this project? Do they seem more or less confident? Do they seem more or less skilled at what they do?

- **Now they know how to give teachings using the flipchart.**
- **Now they know how to give advice about maternal and child health.**
- **They are more sensitive to problems in the community**
- **\They have confidence in what they say and do because they have been trained by the promoters**
- **They are respectful to the community and the community also respects them.**

d. The project will end in October 2010 and the Promoters may not visit the Leader Mothers after that time since there will not be any money. **Do you think that the Care Groups in your communities will continue to meet? Will the Leader Mothers continue to visit mothers with young children and pregnant women? In what ways do you plan to encourage them in that?**

- **They think that the meetings will not continue without direction from the Promoter.**
- **Mothers may still visit one another because they are friends with each other.**
- **Also the promoter will find it difficult to continue the teachings because of lack of resources**

- **Even now that the project is still being implemented there are some Mothers who are unhappy and hard to convince because of the lack of incentives. Mothers do not understand that the project is for their own good and complain.**

Will the Leader Mothers continue to visit mothers with young children and pregnant women?

- **It is possible that the ML will continue to visit them because they are also their neighbors and with the participation in the project the have made friends. In case of necessity we believe they will do it.**

In what ways do you plan to encourage them in that?

- **They say they can try to remember the benefit of the activity to them, for their family, and for their own community.**
- **They say they could encourage them to train other groups of mothers who did not participate in the project and still do not have the teachings, so as to transmit to them as well.**
- **But say it will be difficult to achieve because they [the ML] will always require something to acknowledge the work they do.**

V. Focus Group Guide for Use with Care Group Leader Mothers in former DAP II Areas

Participants: Draw participants for these focus groups from areas where the DAP II was formerly active but where FH has not worked for the past 12 months. It would be best to draw former Leader Mothers from these areas, inviting them from different communities to form each of focus groups (e.g., 2-3 Leader mothers from each of 4-5 different communities to form one focus group).

Introduction: *The purpose of these discussions is for Food for the Hungry, the Ministry of Health of Mozambique and other partners to better understand if Leader Mothers and Care Groups are still active in the communities where FH set up Care Groups from _____ to _____. That project ended in ____, but we would like to know what sort of activities have continued as a result of that project and if you are still seeing any results of that project.*

There are no right or wrong answers to the questions that we will discuss. You should feel free to agree or disagree with others in the group as everyone is entitled to their opinion. Rather than trying to reach a consensus of the group, we want to hear the different ideas that each of you have concerning the questions we have, and we hope that you will all feel comfortable sharing what you think. After we ask each question, we will repeat it to assure you know what we are asking. After that, anyone can respond, agree, disagree, add their comments, etc. We do not want to go around the circle and have each person respond. Instead, we want the group to discuss the question.

Note: For each question, read all of the questions listed for each letter (e.g., "a.") completely and then repeat them so leaders can think about them. It is important to read all of the questions in each question together as you want leaders to discuss the subject and not each respond to each specific question. If in their discussion, no one responds to a particular question, after the discussion you can "probe", repeating part of the question that they did not answer.

1. Let's start by assuring that you are the people that we need to talk with:
   a. **Did you participate in the Care Groups that were formed in this area when FH was working in your community?** If so, how did you participate? Does FH still have Promoters working in your area? (Assure that all participants participated as Leader Mothers during the previous DAP.)

- **Yes we participated.**

- **They participated in learning activities**
- **They made home visits**
- **FH no longer has promoters working in their communities.**

2. Let's talk about what activities you are still doing since the end of the project.

   a. **When FH first started setting up the Care Groups in your area, what sort of activities did you do?** How often did you visit mothers to teach them? How often did you meet with other Leader Mothers in the Care Group?

      a. **The first activity was to education (hygiene, sanitation and nutrition). Promoters educated the ML and ML their beneficiaries.**
      b. **Education was accompanied by visits to homes of beneficiaries to verify if the teachings were practiced**
      c. **Weighing of children to identify children with low weight and then direct them to participate in the Hearth (enriched porridge) sessions.**
      d. **Activity of Savings and rotating credit.**

   How often did you meet with other Leader Mothers in the Care Group?

   - **The teachings of the CG [1] happened 2 times each month**

   - **Mothers visited were those who missed the group teaching for some reason. They were visited in the days following the teaching.**

   b. **Now that FH is not working with the Care Groups in this area, what sort of activities do you do now with each other and with mothers now?** Do you ever visit mothers to teach them? If so, how often? Do you ever meet with other Leader Mothers in the Care Group now? If so, how often? If you do still see mothers and teach them, do you usually do that in groups or through individual home visits?

   - **Now there are not visits for teaching.**

   Do you ever have meetings with other leaders in Groups Mothers Care?

   - **They never had meetings with the ML after the withdrawal of FH**

   If you continue to visit mothers and teach them, you usually do it in groups or through individual home visits?

   - **There are no group meetings**
   - **Mothers visit each other in case of illness or death**
   - **They continue to advise the community related to hygiene, sanitation, washing hands and seeking care in the health post.**
   - **Some still participate in rotating savings and credit groups among themselves.**

c. **Do you think that the mothers have continued to practice some of the things that you promoted during the FH project?** What sort of things are they still doing? What are the things that they are no longer doing?

- **Yes many mothers still practice what they learned.**
- **They use a latrine, bury trash in a pit, and they have a place to wash hands and a dish drying rack.**
- **Mothers also know how to prepare a healthy meal with the products of the farms but it is difficult that they are able to do this. Because of drought or flood or the farms barely produce or produce only a single product and not variety.**

What are the things that they no longer practice?

- **Some do not practice exclusive breastfeeding and breastfeeding when they are pregnant because they continue to believe that this is not good.**
- **They do not go the Health Post in case of illness because they believe in the prophets and witchdoctors.**

d. **If you are still meeting with mothers to teach them, what are the reasons that do you do that?** What do you like about it? If you are not meeting with mothers to teach, what are the reasons that you no longer do that?

- **We have not had meetings for teaching.**
- **We lack direction/orientation from the promoter.**
- **Lack material (The flipcharts no longer exists because of rain or because they are dirty or damaged.)**
- **Lack incentives**
- **We have to go to our farms, we have domestic duties.**

e. **If you are still meeting with other Leader Mothers in the Care Group, what are the reasons that you do that?** What do you like about it? If you are not meeting with other Leader Mothers in the Care Group, what are the reasons that you no longer do that?

No response.

VI. Focus Group Guide for Use with Health Facility Personnel in Areas where Care Groups were Active 2006-2008 (NOT DONE)

Participants: Draw participants for these focus groups from Health Facility Personnel in areas where FH Care Groups were active between 2006 and 2008 and where FH has not worked for the past 12 months. Choose health facility staff who has been serving the same health facility since 2006. Invite personnel who serve different health facilities to form each of focus groups (e.g., 1-2 health facility staff from each of 6-8 different health facilities to form one focus group).

Introduction: *The purpose of these discussions is for Food for the Hungry, the Ministry of Health of Mozambique and other partners to better understand your knowledge and use of the Care Groups set up in each community and changes seen in mother's health practices and health service utilization over the past few years.*

There is no right or wrong answers to the questions that we will discuss. You should feel free to agree or disagree with others in the group as everyone is entitled to their opinion. Rather than trying to reach a consensus of the group, we want to hear the different ideas that each of you have concerning the questions we have, and we hope that you will all feel comfortable sharing what you think. After we ask each question, we will repeat it to assure you know what we are asking. After that, anyone can respond, agree, disagree, add their comments, etc. We do not want to go around the circle and have each person respond. Instead, we want the group to discuss the question.

Note: For most questions, read all of the questions listed for each letter (e.g., "a.") completely and then repeat them so that each person can think about them. It is important to read all of the questions in each question together as you want leaders to discuss the subject and not each respond to each specific question. If in their discussion, no one responds to a particular question, after the discussion you can "probe", repeating part of the question that they did not answer.

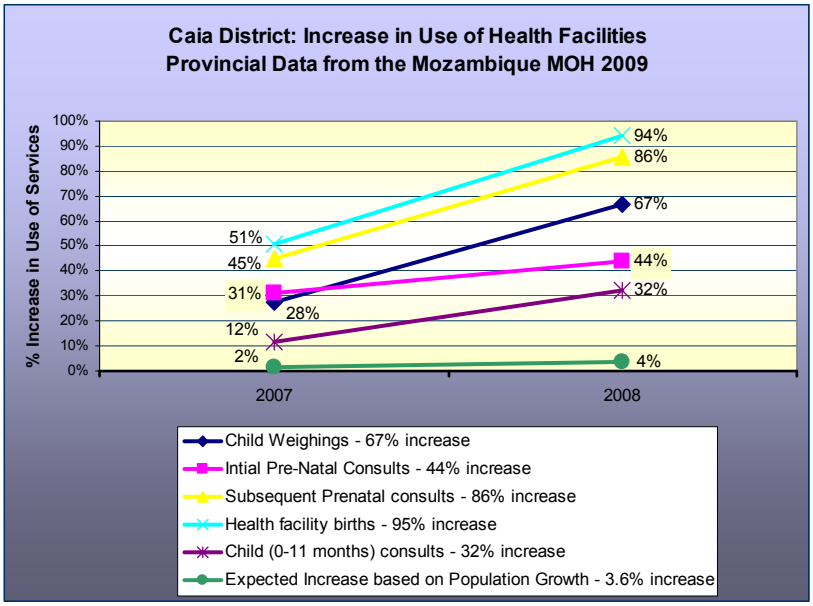
1. Let's start by assuring that you are the people that we need to talk with:
   a. When did you start working in the health facility in which you are currently serving? Were you serving in that health facility when FH was working in nearby project communities? Are you still serving in that same health facility?

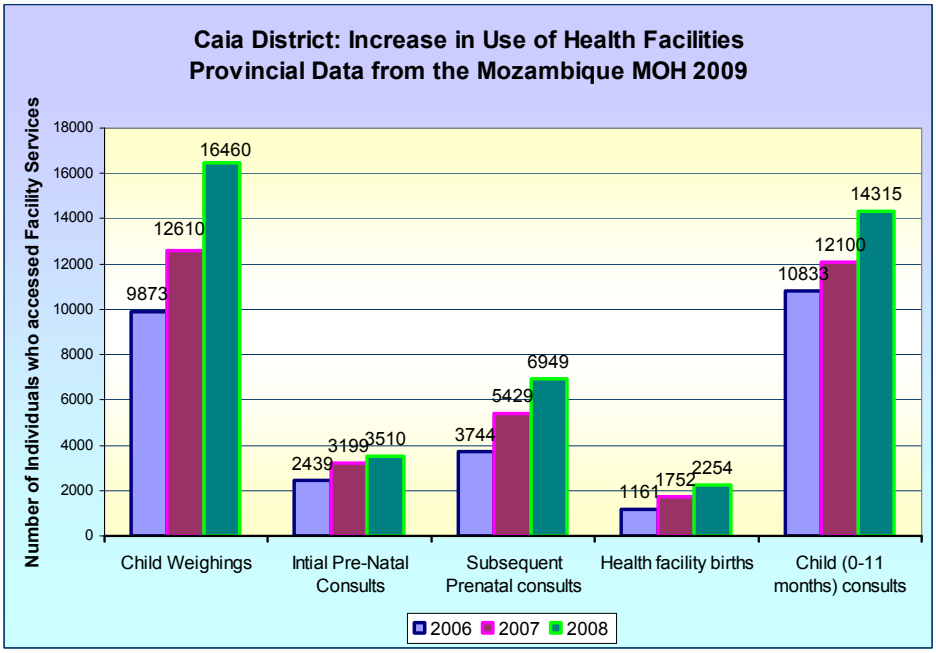
b. Please tell me everything that you know about the Care Groups that were set up in the communities near your health facility. How were they set up? Who attends them? Who goes to the Care Group to train people? What is the purpose of the Care Groups?

c. [Describe the Care Groups to them to correct any misconceptions before asking this question.] **To what degree do you feel the work of the Promoters and Leader Mothers in these communities (where there are or were Care Groups) has been effective in helping reduce child deaths and increasing health service utilization in health facilities?** What changes do you think they bring about? What things have improved with the use of these Care Groups, in your opinion?

d. During this project, we compared mothers who were doing a particular practice with those who were not in something we called **Barrier Analysis studies.** Tell me what you know about that. Did you learn about the results of those studies? Did you use the results of those studies in your work at the health facility? If so, how? In what ways did the information from those studies influence the things that you did at the health facility or in outreach activities?

e. During this project and in some communities, we talked to the mothers of children who had died and interviewed them to learn more about the causes of those deaths (**Verbal Autopsies**). Were those verbal autopsies done in any communities near your health facility? If so, are there any things that you learned from those interviews? In what ways did the information from those autopsies influence the things that you did at the health facility or in outreach activities?




Caia District: Increase in Use of Health Facilities
Provincial Data from the Mozambique MOH 2009
Number of Individuals who accessed Facility Services
18000
16000
14000
12000
10000
8000
6000
4000
2000
0
9873
12610
16460
2439
3199
3510
3744
5429
6949
1161
1752
2254
10833
12100
14315
Child Weighings
Intial Pre-Natal Consults
Subsequent Prenatal consults
Health facility births
Child (0-11 months) consults
2006
2007
2008

ANNEX 2: Eight Success Stories from the Child Survival Program

Collected May 12th, 2010

Provided by Food for the Hungry CS Promoters and Officials

1. Dondo Success Story, How treating Intestinal Worms changed a Family
Shared by Clara Mafarinha

When Leonora's two children eliminated many intestinal worms her husband asked her to forgive him because he had been sleeping around and he knew if he continued his promiscuous behavior his children would get so many worms, it would eventually kill them. He promised to be faithful to Leonora from then on. This happened because in the community people believe that if a child is sick it is because his parents have extramarital partners and if the mother cooks for the children or if the father touches the children their unfaithfulness causes illness or in the case of Leonora's children, round worms.

Before this happened, Leonora was a beneficiary mother in the Leader Mother Joaquina's care group. She didn't give much importance to the meetings Joaquina led that taught mothers about health and nutrition behaviors that would supposedly prevent children's deaths and malnutrition. Leonora only came when she felt like it. So when deworming was scheduled to occur for all the pregnant women and children under five in Joaquina's group of mothers, Joaquina had to make a special trip to Leonora's house to invite her to the event. Leonora didn't come, so the following day the Food for the Hungry promoter, Clara, went to Leonora's house and gave Leonora, who was pregnant, and her two children the deworming medicine, Albendazole. She also counseled Leonora to go the hospital for a prenatal consult. Within two days Leonora's children had passed huge amounts of worms, something that had never happened to them before. It was then that Leonora's husband confessed and repented of the behavior he believed had led to his children's poor state of health. Leonora went to the Promoter to thank her for helping her children and her marriage. A few months later she gave birth to her third child and began to regularly attend the Leader Mother meetings, often being the

first to arrive. Eventually Leonora learned that worms are prevented by practicing good hygiene and sanitation, she even shared this information with her husband.

2. Nhamatanda Success Story

Shared by Fernando Seda

In the Food for the Hungry Child Survival Program all the mother's involved in the program in the Mucombeze community of Nhamatanda reviewed the flipchart that taught about environmental hygiene and that latrines are good because they help avoid illness like diarrhea. Everyone became convinced that latrines were needed and it was decided that the Leader Mothers should be the first to build latrines so their beneficiary mothers would not be doubtful of the importance of having a latrine. The picture above is what the community used as a latrine before the project. Sixty-five Leader Mothers built latrines and some Beneficiary Mothers. A month later I asked the mothers if they had built the latrines. Some said yes and others said that they could not make latrines because their husbands did not have time to cut the posts and bring the thatch because they were drinking. The women who could not convince their husbands to help, asked if I would go and talk to their husbands. I talked to the community leaders and explained the situation. The leaders decided to hold a community wide meeting and in that meeting they passed a law requiring every family to build a latrine. The leader gave the families 60 days to make latrines, but some people were still reluctant to build latrines.

Around that time, UNICEF announced that they had a prize to give to the first community that eliminated open air defection. This encouraged the community leaders to try to enforce the latrine law. They announced that the community police would visit all the homes in the community. The police would not beat the people who refused to build latrines but they would be allowed to remain at that house eating breakfast, lunch, and a dinner that included chicken until the family finished their latrine. So everyone who hadn't made their latrine did so.

The people from UNICEF came to the community. They didn't talk to the community leaders but started visiting households. At each house they would ask the children, "Where do you go the bathroom?" At every house the children said they used a latrine and showed the people from UNICEF their latrine. All the latrines in the village had roofs and lids to cover the hole, some were made with cement and others with wood and palm fronds. UNICEF declared the community of Mucombeze the winner of their competition and placed a sign at the village entrance that says the community is free of open air defection. The prize for this achievement was a school and the rehabilitation of the road that led to the community.

3. Caia District, Chipuazo Community

By Maria dos Santos

In the month of August in 2007, a Leader Mother was making her regular visits to the Beneficiary Mothers in her group. She visited a mother named, Gueta Fole and her son Joao Timotio, even though they were not part of the Care Group. Joao was 17 months old and Gueta's 5th child. Joao's had diarrhea, his eyes were sunken in and his skin wrinkled. The Leader Mother recognized the danger signs of dehydration and encouraged Gueta to take her son to the health post. Already Gueta had lost 2 of her children, one had died from diarrhea and other from an unknown cause so Gueta knew how serious diarrhea could be. But despite the encouragement and counsel of the Leader Mother she would not take Joao to the health post because she was part of a local sect called the Twelve Apostles that does not believe in modern medicine and forbids it's member to use health services. Complicating the situation even further, Gueta's husband was an influential leader in the Twelve Apostle church. The Leader Mother talked to the Promoter, Maria dos Santos, about Joao's case and together they went back to Gueta to try again to convince her to take Joao to the health post or risk loosing him. Gueta knew Joao was close to death and not recovering under her care so she did as advised and went to the health post. Joao recovered and though his father was shocked that his wife had broken the rules of the church and taken Joao to the health post, he also realized that it was this act that had saved his child's life. He permitted Gueta to start attending the Leader Mother's health lessons and openly praised his wife's actions. Gueta and her husband remain in the Twelve Apostle's church, but now the women in that church are allowed to participate in the Care Groups and some are changing their attitudes and taking their children to the health post.

4. **Nhamatanda Culture Shock**

Shared by Fernando Caetano

A Child Survival promoter named Fernando Caetano gives health and nutrition lessons every two weeks to a group of twelve Leader Mothers in Nhamatanda district, in the community of Muegnbeze. If a mother misses a lesson, Fernando visits the mother in her home to share the lesson. When one of his Leader Mothers, Fatima Barais, missed a lesson Fernando went to her house to determine why she didn't come to the group lesson.

Fatima explained that her husband was angry because instead of presenting him with a basin and jug to wash his hands as has been the custom in Nhamatanda for many, many years she asked him to wash his hands using the Tippy-tap she learned how to make in the Fernando's health and nutrition lessons. Her husband felt that his wife was abusing him by not providing the customary basin and jug for hand washing. He said, "If this is what you are going to learn in the health and nutrition meetings then you cannot go. This teaching brings abuse to me!" The Leader Mother Fatima asked Fernando if he would go to her husband and ask for forgiveness on her behalf. The Promoter promised to go and the very early the next morning he went to talk to the husband. The Promoter started the conversation by asking why Fatima was no longer coming to his teachings. The husband repeated what Fatima has said. "I did not like the abuse I received from my wife, telling me to wash my hands in the five gallon jug! She should come to me with the basin and jug so I can wash my hands." The Promoter explained

the Tippy Tap is a better method of hand washing than the basin and jug because it uses very little water and prevents contamination of the jug and water with dirty hands. The husband accepted the explanation and starting sharing with other men in his community the benefits of a Tippy-tap. Fatima was back at the Health and Nutrition lesson the next week.

5. Maringue Success Story

Shared by Zacarias

In my community there is baby boy called Tender (Terno in Portuguese). He is about one year old but his exact birth day has been forgotten. His mother is called Help (Ajuda in Portuguese). One day the Leader Mother was doing a home visit and found that the child was sick, so she took the MUAC reading and found that it was in the red stage – which means severe malnutrition. The ML referred the child immediately to the health post and the child was transferred to the Maringue hospital. In one week the child was recuperated and sent home. When the child arrived at the house the baby was presented to the ML and the MUAC taken again and it was in the yellow stage. The ML explained to Help in her own language how to feed Tender, to give him corn porridge and locally available ingredients like ground peanuts or sesame seeds, malabre (the fruit from the Baobab tree that is rich in iron and vitamin C) and moringa leaves (rich in protein and vitamin C & A). The Mother prepared porridges with these ingredients for Tender. Now the child is healthy and the mother never misses the teachings. She counsels other mothers to do the same.

6. **Success Story involving the Community Development Committee Gorongosa**

"My wife is a Leader Mother"

Shared by Baroso

During a Community Development Committee meeting a 36 year old man from Mucoza, Gorongosa stood up and shared with all the leaders, "My wife is a Leader Mother in Food for the Hungry's Health and Nutrition program and she knows how to identify health problems in children. This started after our seventh child, Castigo, was sick and started to get fat very fast. One day after returning from the FH teaching sessions my wife said that she had learned that Castigo's fat was a sign of malnutrition. He was swelling up and not getting fat at all. I didn't believe my wife, but I didn't stop her from seeking help either. She went to talk to the FH Promoter who explained that she should take the child to the health post quickly. In the health post they said that the

child needed to be hospitalized. He stayed in the hospital for 2 months and returned home to continue recuperating. My wife was given some packets of food to feed Castigo but she was not sure she understood all the hospital's instructions so she sought out the FH Promoter who spoke the same language of Gorongosa to know more about malnutrition. The Promoter indicated a diet full of the fruits of the farms (like vegetables, peanuts, and sesame seeds), good hygiene, and regular deworming would help Castigo grow well. Immediately, Clara took all our children to the health post for deworming. That is why I am proud that she is a Leader Mother, because now my family is healthy and my son is strong."

7. **Manga Success Story**

By Delfina Hanra

A mother beneficiary of the Child Survival Care Group program named Anagtancia had a male child named Giorol that was chronically malnourished and plagued with nearly constant diarrhea. The child's condition worsened until he was admitted to the Health Center of Nhaconjo for nutritional rehabilitation. After being discharged from the health center the Leader Mother, Carlota Luchanhane, visited Anagtancia and her husband. She taught the mother how to make a nutritious porridge for the baby out of local foods. In addition to the formula given to the child in the health center, the mother started to feed Giorol the nutritious porridge and continued breast feeding. When Anagtancia started giving the porridge to Giorol he was 15 months old and weighed just 6.4 kilos. Within just two weeks Giorol had gained .8 kilos or 12% of his original weight. Giorol continued to gain weight and now he is a healthy child. The Leader Mother continued to visit the family and teach about hygiene and sanitation.

8. Gorongosa Success Story

Augusto Manuel

Mirija Mauricio is a Leader Mother and part of the 3rd CG in Nhaurauga. She had lost 2 children before Food for the Hungry's program entered her community in April of 2008. One of the children who died was given porridge to eat on the day he was born and later died of diarrhea. Her second child died because of fever, likely caused by malaria. When the child was hot with the fever Mirija's neighbors told her to bathe the child in warm water and the child would recuperate quickly. Instead the child died while Mirija was bathing him in the hot bath. When Mirija started participating in the Child Survival program as a Leader Mother she learned how to prevent illness in young children and care for those that fell sick. When she became pregnant again and had a third child, she gave this child only breast milk from the day he was born until he was six months of age. Mirija teaches her Beneficiary Mothers, women in her neighborhood, and women at the church that when a child has a high fever this is a dangerous sign and the child needs to go immediately to the health post. She tells the mother's to use cool cloths to bathe the child when taking her to the health post. If a child has diarrhea she teaches the mothers to give more liquids, like Oral Rehydration Salts, and take the child to the health post. Mirija became so well respected and her advice so widely sought that her pastor invited her to teach every Thursday at the women's church meeting about good health practices. Although Mirija cannot read she shares about her faith and the life saving health messages she has learned from her participation in the Child Survival program. Mirija is in the first year of the three year government sponsored literacy program. Her husband is proud of her and the work she does for the good of their family and others.

Annex 3: KPC Questionnaire for BM Portuguese

KPC da Mãe Benefeciaria

►Assinale com ☒ somente 1 resposta por cada questão excepto para aquelas que indicarem o contrario
►Não deixe nenhuma pergunta em branco/sem resposta
►Use 3 imagens ampliadas para o auxiliar nas ultimas perguntas do questionario

□

O entrevistador assinala se a Mãe Beneficiária (MB) é do Distrito da Fase I ou da Fase II:	❑ 1. Mãe Beneficiária da Fase I ❑ 2. Mãe Beneficiária da Fase II

No.	**Perguntas**	**Respostas**
1	Quantos anos tem? *Sonde: Qunatos anos tinha quando teve o útimo filho/a?*	_____ Anos ❑ 99. Não tem certeza / Não Respondeu
2	Alguma vez frequentou a escola?	❑ 1. Sim ❑ 2. Não ⇨⇨⇨ SALTAR PARA A PERGUNTA 4
3	Quais são as suas habilidades literárias (estudou até que classe)?	_____ Anos ❑ 99. Não tem certeza / Não Respondeu

4	Há quantos anos está no projecto de sobrevivência infantil da fh?	_____ Anos ❑ 99. Não tem certeza / Não Respondeu
5	Tem algum/a filho/a com menos de dois anos de idade?	❑ 1. Sim ❑ 2. Não ❑ 3. Não tem certeza/ Não sabe
6	Está grávida?	❑ 1. Sim ❑ 2. Não ❑ 3. Não tem certeza / Não sabe
7	Onde é que teve o seu último parto?	❑ 1. Hospital ou posto de saúde ❑ 2. Em minha casa ou em casa de uma outra pessoa ❑ 3. A caminho do hospital ❑ 5. Outro _____ _____ ❑ 99. Não tem certeza / Não sabe
8	Teve as mesmas Mães Líderes durante a implementação do projecto de sobrevivência infantil?	❑ 1. Sim ❑ 2. Não ❑ 3. Não tem certeza / Não sabe
9	Quantas Mães Beneficiárias as suas Mães Líderes ensinam? *(Deixe as respondentes fazerem uma estimativa se elas não tiverem a certeza)*	_____ Nº de Mães Beneficiárias ❑ 99. Não tem certeza / Não sabe
10	Normalmente quantas Mães Beneficiárias participam nas aulas em grupo orientadas pela Mãe Líder?	_____ Nº de Mães Beneficiárias ❑ 99. Não tem certeza / Não sabe

11	Nos últimos 12 meses, quantas Mães Beneficiárias desistiram do seu Grupo de Cuidados de Mães Líderes?	_____ Nº de Mães Beneficiárias ❑ 99. Não tem certeza / Não sabe
12	Porque foi que as Mães Beneficiárias abandonaram o projecto? *Deixe responder a vontade, não dê sugestões. Marque todas respostas aplicáveis.*	❑ A. Falta de incentivos ❑ B. Mudou para uma outra zona ❑ C. Perdia muito tempo a aprender assuntos que já conhecia ❑ D. Falta de interesse ❑ E. Foi substituida pela comunidade ou pela Mãe Lídere porque não ensinava as outras mães ❑ F. Andava muito ocupada na machamba ❑ G. Outro _____ ❑ 99. Não tem certeza / Não sabe
	Entrevistador: Agora vou fazer algumas perguntas acerca do uso dos álbuns seriados durante as sessões em grupo.	
13	Com que regularidade a sua Mãe Líder partilha mensagens educacionais consiguo usando o álbum seriado?	❑ 1. Uma vez por semana ❑ 2. Uma vez de quinze em quinze dias ❑ 3. Uma vez por mês ❑ 4. Uma vez de dois em dois meses ❑ 5. Outro _____ ❑ 6. Nunca partilhou mensagens comigo ⇨⇨ **FIM DO INQUÉRITO**

		❑ 99. Não tem certeza / Não sabe
14	A Mãe Líder partilha mensagens educacionais consigo em encontros em grupo ou em visitas domiciliárias?	❑ 1. Apenas através de encontros em grupo ❑ 2. Geralmente através de encontros em grupo e algumas visitas domiciliárias ❑ 3. Apenas através de visitas domiciliárias ⇨⇨⇨ **SALTAR PARA O Nº 19** ❑ 4. Geralmente através de visitas domiciliárias e algumas aulas em grupo ❑ 5. Outro _____ ❑ 99. Não tem certeza / Não sabe
15	Quanto tempo leva a pé para ir aos encontros em grupo orientados pela Mãe Líder?	_____ minutos ❑ 99. Não tem certeza / Não sabe
16	Normalmente, quanto tempo duram os encontros em grupo orientados pela Mãe Líder?	❑ 1. Menos de uma hora ❑ 2. Entre uma à duas horas ❑ 3. Duas ou mais horas ❑ 4. Outro _____ ❑ 99. Não tem certeza / Não sabe
17	Nos últimos três meses, em média, em quantas sessões de aulas em grupo participou? Sonde: Todos encontros, na maior parte dos encontros, em	❑ 1. Todos encontros (90% ou mais) ⇨⇨⇨ **SALTAR PARA O Nº 19** ❑ 2. Maior parte dos encontros (75-89% ou mais) ❑ 3. Alguns encontros (40-74%)

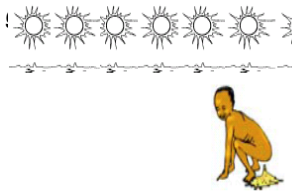
	alguns encontros, em poucos encontros ou nunca participou?	❑ 4. Poucos encontros (<40%) ❑ 5. Nunca participou ❑ 99. Não tem certeza / Não sabe
18	Qundo faltou a alguma sessão de ensino em grupo o que foi que aconteceu, se aconteceu algo?	❑ 1. A Mãe Líder visitou-me em minha casa e pratilhamos a aula ❑ 2. Visitei a Mãe Lídere para receber a aula ❑ 3. Levei o material no encontro seguinte ❑ 4. Pedi a uma outra Mãe Beneficiária para me explicar a lição ❑ 5. Não aconteceu nada ❑ 6. Outro _____ _____ ❑ 99. Não tem certeza / Não sabe
19	Normalmente quanto tempo duravam as visitas domiciliárias que a Mãe Líder fazia à sua casa?	❑ 1. Menos de uma hora ❑ 2. Entre uma à duas horas ❑ 3. Duas ou mais horas ❑ 4. Outro _____ ❑ 88. Não aplicável ❑ 99. Não tem certeza / Não sabe
20	Quando a Mãe Líder partilhava as lições do álbum seriado	❑ 1. Nenhuma outra pessoa escutou

	consigo em sua casa alguém mais escutava? Se sim, quem?	❑ 2. Filha ❑ 3. Filho ❑ 4. Mãe ❑ 5. Pai ❑ 6. Amiga ❑ 7. Amigo ❑ 8. Marido ❑ 9. Outro ❑ 88. Não aplicável ❑ 99. Não tem certeza / Não sabe
21	Consegue ler as palavras que estão escritas no álbum seriado?	❑ 1. Sim, consigo ler as palavras no álbum seriado ❑ 2. Não, não consigo ler as palavras no álbum seriado ❑ 3. Consigo ler algumas palavras mas não todas ❑ 4. Outro _____ _____ ❑ 99. Não tem certeza / Não sabe

22	Qunado a Mãe Líder partilhou consigo as mensagens do álbum seriado, ela fazia algo mais que explicar o que as imagens transmitiam?	❑ 1. Sim ❑ 2. Não ⇨⇨⇨ SALTAR PARA A PERGUNTA Nº 24 ❑ 3. Não tem certeza / Não sabe
23	What educational methods did she use in her presentations? Não instigue. Marque todas as respostas aplicáveis.	❑ A. Jogos ❑ B. Histórias ❑ C. Demonstrações ❑ D. Fazia perguntas, orientava discussões ou debates ❑ E. Fazia a revisão da matéria da sessão anterior ❑ F. Pedia a Mãe Beneficiária para fazer o resumo da matéria ❑ G. Oração ❑ H. Outro _____ _____ ❑ 99. Não tem certeza / Não sabe
24	Algumas mães que participam no projecto adoptaram boas práticas e outras não adoptaram. Porquê acha que algumas mães conseguiram mudar as suas práticas? Não instigue. Marque todas as respostas aplicáveis.	❑ A. Antes do projecto as mães não conheciam as boas práticas. Quando tiveram conhecimento adoptaram-nas ❑ B. Níve social, económico e culturas das Mães Líderes ❑ C. Elas compreenderam que a mudança era importante, necessária e benéfica

		❑ D. Para ajudar as outras mães na comunidade a resistirem aos hábitos culturais ❑ E. Telas estavam preocupadas com o bem-estar da família delas ❑ F. Outro _____ ❑ 99. Não tem certeza / Não sabe
25	Que mudanças fez na sua casa como resultado deste projecto? Não instigue. Marque todas as respostas aplicáveis.	❑ A. Adoptei práticas nutricionais saudáveis ❑ B. Adoptei práticas de higiene e sanitárias saudáveis ❑ C. Fui mais capaz e confinate de ensinar (usando o álbum seriado) ❑ D. Consigo identificar sinais de perigo nas crianças e nas mulheres grávidas e aconselhá-las devidamente ❑ E. Consigo identificar sinais de perigo nas crianças e nas mulheres grávidas e aconselhá-las devidamente ❑ F. Consigo dar conselhos sobre as doenças de infância (tal como a diarreia, pneumonia, malária, etc.) ❑ G. Consigo aconselhar sobre a amamentação apropriada ❑ H. Outro _____❑ _____ ❑ 99. Não tem certeza / Não sabe
	Entrevistador: Agora vou fazer algumas perguntas acerca dos cuidados que dá ao seu filho.	

26	Com que idade deve começou a dar água, chá ou papas ao seu bebé?	_____ meses de idade ❑ 99. Não tem certeza / Não sabe
27	Nos últimos 12 meses quantas vezes foi ao hospital/centro de saúde?	_____ vezes por ano ❑ 99. Não tem certeza / Não sabe
28	Quais são os sinais de perigo que indicam que uma criança precisa de ser levada imediatamente ao centro/posto de saúde? *Sonde: Conhece alguns outros sinais?* *Continue a perguntar por mais sinais ou sintomas até a mãe não poder lembrar-se de outro*	❑ A. Diarreia sanguinolenta ❑ B. Recusa consumir líquidos e sólidos ❑ C. Fraqueza ou letargia, não consegue acordar ❑ D. Diarreia há duas semanas ❑ E. Febres altas ❑ F. Convulções ❑ G. Vómitos ❑ H. Outro _____ _____ ❑ 99. Não tem certeza / Não sabe
29	Qundo é que deve lavar as suas mãos com sabão ou cinza? *Sonde: Conhece algumas outras situações?* *Continue a pedir mais exemplos até a mãe não poder lembrar-se de outros momentos adicionais.*	❑ A. Depois de usar ou limpar a latrina ❑ B. Depois de limpar o ânus da criança ou depois de limpar o nariz da criança ❑ C. Quando quiser preparar comida

	Circule tododos os sinais mencionados, mas não sig	❑ D. Quando quiser preparar qualquer alimento ou dar de comer as crianças ❑ E. Outro _____ _____ ❑ 99. Não tem certeza / Não sabe
	Entrevistador: Agora vou mostrar algumas imagens e fazer algumas perguntas acerca das imagens.	
30	Qual é a mensagem chave que esta imagem pretente transmitir? ***O enumerador deve ter uma imagem em ponto*** ***a.*** 	❑ 1. Diarreia há duas semanas – isso é uma emêrgencia ❑ 2. Outra mensagem incorrecta ❑ 3. Outra mensagem correcta:_____ _____ ❑ 99. Não tem certeza / Não sabe
31	Qual é a mensagem chave que esta imagem pretente transmitir? ***O enumerador deve ter uma imagem em ponto grande da imagem abaixo para mostrar a Mãe Beneficiária.*** _____ 	❑ 1. ALEITAMENTO como prevenção da Malnutrição e outras doenças ❑ 2. Outra mensagem incorrecta ❑ 3. Outra mensagem correcta:_____ _____

		❑ 99. Não tem certeza / Não sabe
32	Qual é a mensagem chave que esta imagem pretente transmitir? ***O enumerador deve ter uma imagem em ponto grande da imagem abaixo para mostrar a Mãe Beneficiária.*** 	❑ 1. Tomar medicamento (desparisantes) de 6 em 6 meses depois fazer 1 ano de idade ❑ 2. Outra mensagem incorrecta ❑ 3. Outra mensagem correcta:_____ _____ ❑ 99. Não tem certeza / Não sabe
33	Voce acredita que vale mais o homen que a mulher, vale mais a mulher que a homen, ou sao iguais?	❑ 1. Homen vale mais ❑ 2. Mulher vale mais ❑ 3. São Iguais ❑ 99. Não sabe/ Nenhuma Reposta
34	É correcto o marido bater na mulher por ele estar insatisfeito com ela?	❑ 1. Sim ❑ 2. Não ❑ 99. Não tem certeza / Não sabe

ANNEX 4: KPC Questionnaire for LM Portuguese

PROGRAMA DE SOBREVIVENCIA INFANTIL
PESQUISA OPERACIONAL
KPC MÃES CHEFES

►Assinale com ☒ somente 1 resposta por cada questão excepto para aquelas que indicarem o contrario
►Não deixe nenhuma pergunta em branco/sem resposta
►Use 3 imagens ampliadas para o auxiliar nas ultimas perguntas do questionario

Assinale com ☒ se a ML é do Distrito da Fase I ou Fase II	❑ 1. MC do Distrito da Fase I ❑ 2. MC do Distrito da Fase II
No.	**Perguntas** / **Respostas**
1	Que idade tem? **Sondagem** *: Que idade tinha quando teve o seu ultimo filho*? / _____ Anos
2	Já alguma vez ferquentou a escolal? / ❑ 1. Sim ❑ 2. Não ⇨⇨⇨ **Salte para pergunta 4**
3	Quantos anos de escolaridade você ferquentou? / _____ Anos
4	A quantos anos trabalha para fundação contra fome como MC do projecto de Sobrevivência Infantil? / _____ Years

5	Você tem uma criança menor de 2 anos de idade?	❑ 1. Sim ❑ 2. Não ❑ 99. Não Sabe/ Não Respondeu
6	Actualmente você está gravida?	❑ 1. Sim ❑ 2. Não ❑ 99.Não Sabe/ Não Respondeu
	Interviewer: Now I am going to ask you some questions about your experience with the child survival project	
7	Como você foi selecionada para ser Mãe Lider?	❑ 1. Eleicta pelas outras mães do grupo ❑ 2. Convidada a ser MC pelos Lideres Comunitarios ❑ 3. Convidada a ser MC pelo Promotor ❑ 4. Outro (especifique)_____ ❑ 99. Não Sabe/ Não Respondeu
8	De acordo com os teus conhecimentos quantas ML estão actualmente registadas nos teu grupo de cuidado?	_____ # de MC ❑ 99. Não Sabe/ Não Respondeu
9	Em média quantas MC tem estado presentes nos ensinos do Promotor nos ultimos 3 meses?	_____ # de MC ❑ 99. Não Sabe/ Não Respondeu
10	Nos ultimos 12 meses quantas MC do seu grupo desistiram dos ensinos do Promotor?	_____ # de MC por grupo ❑ 99. Não Sabe/ Não Respondeu
11	Na sua opinião, porquê algumas MC desistem dos ensinos? *Deixe responder a vontade, não dê sugestões. Marque todas respostas*	❑ A. Falta de incentivos ❑ B. Migração para outras areas

	dadas.	❑ C. Demasiado tempo despendido com revisão de Tópicas já conhecidos ❑ D. Falta de interesse ❑ E. Substituida pelo promotor porque não dava ensino as suas Benefeciarias ❑ F. Ocupação com o trabalho nas machambas ❑ G. Outro _____ ❑ 99. Não Sabe/ Não Respondeu
12	Nos ultimos 3 meses quantos ensinos do Promotor você foi capaz de assistir?**Sondagem*:*** *Todos ensinos*, muitos ensinos, alguns ensinos, poucos ensinos ou nunca foi capaz de assistir?	❑ 1. Todos ensinos (>90%) ⇨⇨ **Salte para questão 14** ❑ 2. Muitos ensinos (75-89% or more) ❑ 3. Alguns ensinos (40-74%) ❑ 4. Poucos ensinos (<40%) ❑ 5. Nunca foi capaz de assistir ❑ 99. Não Sabe/ Não Respondeu
13	O que acontecer quando você perde um ensino do Promotor?	❑ 1. Promotor visita a minha casa para dar o ensino ❑ 2. Eu visito o Promotor para receber o ensino ❑ 3. Eu recebo o material no ensino seguinte ❑ 4. Eu peço uma outra mãe para me explicar a lição ❑ 5. Nada acontece ❑ 6. Outro _____

		❑ 99. Não Sabe/ Não Respondeu
14	Quanto tempo você leva para chegar ao local de concentração para o ensino?	_____ ___ minutos ❑ 99. Não Sabe/ Não Respondeu
	Interviewer: Now I am going to ask you some questions about your experience with using flipcharts in this program	
15	Quantas vezes se encontrava com o Promotor para receber a lição do album seriado?	❑ 1. Uma vez por semana ❑ 2. Uma vez em duas semanas ❑ 3. Uma vez por mês ❑ 4. Uma vez em cada 2 meses ❑ 5. Outro _____ ❑ 6. Nunca tem se encontrado com o Promotor ❑ 99. Não Sabe/ Não Respondeu
16	Quando recebia o ensino atraves do album seriado você lia as palavras escritas no album para ajudar a recordar as menssagens chave?	❑ 1. Sim eu leio as palavras escritas ❑ 2. Não, eu não leio as palavras escritas ❑ 3. Eu leio algumas palavras escritas mas uso mais as imagens ❑ 4. Outro _____ ❑ 99. Não Sabe/ Não Respondeu
17	Com quantas Mães Beneficiarias partilhava as menssagens do album seriado?	_____ # de MB ❑ 99. Não Sabe/ Não Respondeu
18	Com que regularidade partilhava as menssagens dos album seriado com	❑ 1. Uma vez por semana

	as suas benefeciarias?	❑ 2. Uma vez em duas semanas ❑ 3. Uma vez por mês ❑ 4. Uma vez em dois meses ❑ 5. Outro_____ ❑ 99. Não Sabe/ Não Respondeu
19	Quando ensina as sua Benefeciarias que outro tipo de métodos de ensino você usa para além de explicar as figuras do album seriado? *Deixe responder a vontade, não dê sugestões. Marque todas respostas dadas.*	❑ A. Jogos ❑ B. Dramas ❑ C. Demontrações ❑ D. Explicação de imagens ❑ E. Debates sobre o tema ❑ F. Outras_____ ❑ 99. Não Sabe/ Não Respondeu
20	Normalmente partilhava as lições do album seriado com as suas Benefeciarias em grupo ou em visita a casa delas?	❑ 1. Apenas nos grupos de ensino ❑ 2. Maior parte das vezes nos grupo de ensino e faz visista apenas aquelas mães que perderam a sessão de ensino ❑ 3. Somente atraves de visistas domiciliarias ❑ 4. Maior parte das vezes atraves de visitas domiciliarias e algumas vezes ensinos em grupo ❑ 5. Outros _____

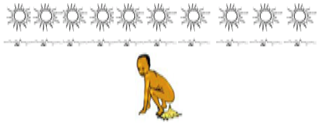
		❑ 99. Não Sabe/ Não Respondeu
21	Quanto tempo levava a pé para ir a casa da mãe beneficiária mais próxima?	_____ ___ minutos ❑ 99. Não Sabe/ Não Respondeu
22	Quanto tempo levava a pé para ir a casa da mãe beneficiária mais distante?	_____ ___ minutos ❑ 99.Não Sabe/ Não Respondeu
23	Normalmente, quanto tempo é que duravam os encontros em grupo com as mães beneficiárias?	❑ 1. Menos de uma hora ❑ 2. Uma hora e meia ❑ 3. Duas horas ❑ 4. Mais de duas horas ❑ 5. Outro _____ ❑ 99. Não tem certeza / Não sabe
24	Normalmente, quanto tempo é que duravam os encontros em casa das mães beneficiárias?	❑ 1. Menos de uma hora ❑ 2. Entre uma a duas horas ❑ 3. Duas horas ou mais ❑ 4. Outro _____ ❑ 99. Não tem certeza / Não sabe
	Interviewer: Now I am going to ask you a few questions about Community leaders and their role in the child survival project	
25	Nos últimos 12 meses, com que regularidade se reunia com os Líderes Comunitários para falar acerca do projecto de sobrevivência infantil?	❑ 1. Uma vez ou mais por mês ❑ 2. De dois em dois meses

		❑ 3. De três em três meses ❑ 4. De seis em seis meses ❑ 5. Uma vez por ano ❑ 6. Nunca ❑ 99. Não tem certeza / Não sabe
26	Como é que os Líderes Comunitários apoiaram o projecto de sobrevivência infantil? *Deixe responder a vontade, não dê sugestões. Marque todas respostas dadas.*	❑ A. Encorajaram as ML e as MB a participarem nos ensinamentos em grupo ❑ B. Encorajaram as ML e as MB a porem em prática os ensinamentos que receberam ❑ C. Ajudaram a explicar o projecto às MLe às MB ❑ D. Apoiaram na resolução de conflitos ❑ E. Modelaram o comportamentos dos promotores através do projecto de sobrevivência infantil ❑ F. Adoptaram leis que exigiam que as famílias adoptassem comportamentos de sobrevivência infantil ❑ G. Ajudaram as mães a procurarem cuidados sanitários no posto de saúde ❑ H. Não ajudaram ❑ I. Outro _____ ❑ 99. Não tem certeza / Não sabe
	Entrevistador: Agora vou lhe fazer algumas perguntas acerca do seu papel como ML	

27	Na sua opinião, as pessoas da sua comunidade respeitam-lhe mais por ser Mãe Líder?	❑ 1. Sim ❑ 2. Não ⇨⇨⇨ SALTE PARA O Nº 29 ❑ 3. Não tem certeza / Não respondeu
28	Quem lhe respeita mais agora do que quando não era Mãe Líder? *Deixe responder a vontade, não dê sugestões. Marque todas respostas aplicáveis.*	❑ A. Marido ❑ B. Os pais ou os pais/familiares do marido ❑ C. Líderes Comunitários ❑ D. Outras mães/mulheres ❑ E. Família alargada (Avós, Tia, Tio, Cunhado, etc..) ❑ F. Pessoal do Centro de Saúde ❑ G. Outro _____ ❑ 99. Não tem certeza / Não sabe
29	Algumas mães no projecto adoptaram boas práticas e outras não adoptaram. Porque é que acha que algumas mães conseguiram mudar as práticas delas? D*eixe responder a vontade, não dê sugestões. Marque todas respostas aplicáveis.*	❑ A. As mães tinham conhecimento das boas práticas antes de chegar o projecto. Quando elas tomaram conhecimento elas adotaram as práticas ❑ B. Nível social, económico e cultural das Mães ❑ C. Elas compreenderam que a mudança era importante, necessária e benéfica ❑ D. Para ajudar as outras mães na comunidade a resistirem aos hábitos culturais ❑ E. Elas estavam preocupadas com o bem-estar da família delas ❑ F. Outro _____ ❑ 99. Não tem certeza / Não sabe

30	Que mudanças é que notou em si mesma como resultado da implementação deste projecto? **Sonde:** Q***ue habilidades ganhou por ser Mãe Líder neste projecto?*** *Deixe responder a vontade, não dê sugestões. Marque todas respostas aplicáveis.*	❑ A. Adoptei práticas nutricionais saudáveis ❑ B. Adoptei práticas de higiene e sanitárias saudáveis ❑ C. Fui mais capaz e confinate de ensinar (usando o álbum seriado) ❑ D. Consigo identificar sinais de perigo nas crianças e nas mulheres grávidas e aconselhá-las devidamente ❑ E. Consigo identificar sinais de perigo nas crianças e nas mulheres grávidas e aconselhá-las devidamente ❑ F. Consigo dar conselhos sobre as doenças de infância (tal como a diarreia, pneumonia, malária, etc..) ❑ G. Consigo aconselhar sobre a amamentação apropriada ❑ H. Outro _____ ❑ 99. Não tem certeza / Não sabe
31	Nos últimos 12 meses, quantas vezes falou com o pessoal da saúde acerca de assuntos relacionados com o projecto de sobrevivência infantil? Uma vez, duas à quatro vezes, quatro à seis vezes ou seis ou mais vezes?	❑ 1. Uma vez ❑ 2. Duas a quatro vezes ❑ 3. Quatro a seis vezes ❑ 4. Seis ou mais vezes ❑ 5. Nunca ❑ 6. Outro _____ ❑ 99. Não tem certeza / Não sabe

	Entrevistador: Agora vou lhe fazer algumas perguntas acerca de cuidar do/a seu/sua filho/a e lavagem das mãos.	
32	Com que idade deve começou a dar água, chá ou papas ao seu bebé?	_____ meses de idade. ❑ 99. Não tem certeza / Não sabe
33	Quais são os sinais de perigo que indicam que a criança deve ser levada imediatamente ao posto de saúde? ***Sonde:*** *Conhece alguns outros sinais?* Continue a perguntar por mais sinais ou sintomas até a mãe não poder lembrar-se de outros sinais adicionais de perigo. *Circule todos sinais mencionados, mas NÃO faça nenhumas sugestões.*	❑ A. Diarreia sanguinolenta ❑ B. Recusa consumir líquidos e sólidos ❑ C. Fraqueza ou letargia, não consegue acordar ❑ D. Diarreia há duas semanas ❑ E. Febres altas ❑ F. Convulsões ❑ G. Vómitos ❑ H. Outro _____ ❑ 99. Não tem certeza/Não sabe
34	Quando é que deve lavar as suas mãos com sabão ou cinza? ***Sonde:*** *Conhece algumas outras situações?* Continue a pedir mais exemplos até a mãe não poder lembrar-se de outros momentos adicionais. *Circule todos exempos mencionados, mas NÃO sugira nada.*	❑ A. Depois de usar ou limpar a latrina ❑ B. Depois de limpar o ânus da criança ou depois de limpar o nariz da criança ❑ C. Quando quiser preparar comida ❑ D. Quando quiser preparar qualquer alimento ou dar de comer as crianças ❑ E. Outro _____ ❑ 99. Não tem certeza / Não sabe

35	Voce acredita que o homem vale mais que a mulher, a mulher vale mais que o homen ou são todos iguais ?	❑ 1. O homen vale mais ❑ 2. A mulher vale mais ❑ 3. São iguais ❑ 99. Não sabe/ Não respondeu
36	É correcto o marido bater na mulher por ele estar insatisfeito com ela?	❑ 1. Sim ❑ 2. Não ❑ 99. Não tem certeza / Não sabe
	Entrevistador: Agora vou mostrar algumas imagens e fazer algumas perguntas acerca das imagens.	
37	Qual é a mensagem chave que esta imagem pretente transmitir? O entrevistador *deve ter uma imagem em ponto grande da imagem abaixo para mostrar a mãe.* 	❑ 1. Diarreia há duas semanas – isso é uma emergência ❑ 2. Outra mensagem incorrecta ❑ 3. Outra mensagem correcta:_____ ❑ 99. Não tem certeza / Não sabe
38	Que mensagem chave esta imagem pretende transmitir? O entrevistador *deve ter uma imagem em ponto grande da imagem abaixo para mostrar a mãe.* 	❑ 1. ALEITAMENTO como prevenção da má nutrição e outras doenças ❑ 2. Outra mensagem incorrecta

		❑ 3. Outra mensagem correcta:_____ ❑ 99. Não tem certeza / Não sabe
39	Que mensagem chave esta imagem pretende transmitir? *O enumerador deve ter uma imagem em ponto grande da imagem abaixo para mostrar a mãe.* 	❑ 1. Tomar medicamento (desparisantes) de 6 em 6 meses depois de completar 1 ano de idade ❑ 2. Outra mensagem incorrecta ❑ 3. Outra mensagem correcta:_____ ❑ 99. Não tem certeza / Não sabe

ANNEX 5: KPC Questionnaire for Promoters Portuguese

KPC PARA PROMOTORES		
Assinale somente uma resposta por cada questão excepto para aquelas que indicarem o contrario Não deixe nenhuma pergunta em branco		
Assinale com X se o Promotor é do Distrito da Fase I ou Fase II		❑ 1. Promotor da Fase I
		❑ 2. Promoter Promotor da Fase II
No.	**Perguntas**	**Respostas**

1	Sexo do respondente?	❑ 1. Femenino ❑ 2.Masculino
2	Que idade tem? **Sondagem** ***:*** *Que idade tinha no seu ultimo aniversario*?	_____ Anos
3	Ja alguma vez frequentou a escola?	❑ 1.Sim ❑ 2. Não ⇨⇨⇨ **Salte para a Pergunta 5**
4	Quantos anos de escolaridade você ferquentou?	_____ Anos
5	A quantos anos trabalha para fundação contra fome como Promotor do projecto de Sobrevivência Infantil?	_____ Anos
6	Você é Promotor de Sobrevivência Infantil do Distriti da Fase I ou Fase II?	❑ 1. Fase I ❑ 2. Fase II ❑ 99. Não sabe/Não Respondeu
7	Antes de começar a trabalhar para o projecto, vocçê ja vivia pelo menos 3 meses na comunidade onde trabalha?	❑ 1. Sim ❑ 2. Não ❑ 99. Não sabe/Não Respondeu
	Agora vou fazer perguntas acerca das MC dos grupos que você ensina	

8	Quantas Mães estão em média registadas no seus Grupos de MC? On average, how many mother leaders are registered in your mother leader groups?	_____ Nº de MC
9	Em media quantas MC tem estado presentes em cada sessão de enssino ?	_____ Nº de MC
10	Quanto tempo normamente durava a sessão de ensino em grupo com as MC?	❑ 1. Menos de 1 hora ❑ 2. 1 hora e 30 minutos ❑ 3. 2 horas ❑ 4. Mais de duas hora ❑ 5. Outro _____ ❑ 99. Não sabe/Não Respondeu
11a	Quantas MC em média faltavam aos ensinos em grupo?	_____ Nº de MC que faltavam as ensinos em grupo
11b	Quantas Mães em média você visita em suas casas por causa de elas terem perdido o ensino em grupo num periodo de 2 semanas?	_____ Nº Mães visitadas em sua casa por mês?

12	Quantas MCs em média por cada grupo de MCs desistiram do programa nos ultimos 12 meses? On average how many mother leaders dropped out of the program per group of mother leaders in the last 12 months?	_____ Nº de MC por grupo de MC **Se Pergunta 12 for 0 Salte para a Pergunta 13**
13	Porquê motivos as MCs desistem do projecto?<u>*São premitidas Multiplas Respostas. Assinale todas as respostas dadas*</u>	❑ A. Falta de incentivos
		❑ B. Migração para outras areas
		❑ C. Demasiado tempo despendido com revião de Tópicas já conhecidos
		❑ D. Falta de interesse
		❑ E. Replaced by the community or promoter because not teaching other mothers
		❑ F. Ocupação com o trabalho nas machambas
		❑ G. Outros _____
		❑ 99. Não sabe/Não Respondeu
14	Quantas MCs nos grupos de cuidado partilham as lições que aprendem com todas as suas Mães Benefeciarias? Todas, muitas, algumas, umas	❑ 1.Todasl (90% ou mais)
		❑ 2. Muitas (75-89% ou mais)
		❑ 3. Algumas (40-74%)

	poucas ou nenhumas?	❑ 4. Umas poucas (<40%)
		❑ 5. Nenhuma
		❑ 99. Não sabe/Não Respondeu
15	Quantas MC nos grupos de cuidado são capazes de ler as menssagens do album seriado? Todas, muitas, algumas, umas poucas ou nenhumas?	❑ 1.Todasl (90% ou mais)
		❑ 2. Muitas (75-89% ou mais)
		❑ 3. Algumas (40-74%)
		❑ 4. Umas poucas (<40%)
		❑ 5. Nenhuma
		❑ 99. Não sabe/Não Respondeu
16	Voçê usa o plano de lição antes ou durante a sessão de ensino das MCs?	❑ 1. Sim
		❑ 2. Não
		❑ 99. Não sabe/Não Respondeu
17	Que tipos de métodos de ensino usa quando ensina as MCs? C70	❑ 1. Jogos
		❑ 2. Dramas
		❑ 3. Demonstrações
		❑ 4. Explicação de imagens
		❑ 5. Debate das questões
		❑ 6. Outras _____

		❑ 99. Não sabe/Não Respondeu
	Agora vou fazer Perguntas acerca do Lideres Comunitarios do Projecto	
	Quantas vezes você se encontrou com os Lideres da sua cominidades nos ultimos 3 meses?	❑ 1. 1-3 vezes
		❑ 2. 4-6 vezes
		❑ 3. 7-9 vezes
		❑ 4. 10 ou mais vezes
		❑ 5. Nunca
18		❑ 99. Não sabe/Não Respondeu
19	De que maneira os Lideres comunitarios tem colaborado com o projecto de sobrevivencia infantil? *São premitidas Multiplas Respostas. Assinale todas as respostas dadas*	❑ A. Encourajar as MLs e MBs a participar nos ensinos em grupo
		❑ B. Encourajar as MLs e MBs a por em pratica os ensinamentos recebidos
		❑ C. Ajudar no esclarecimento as Mls e MBs acerca do projecto
		❑ D. Colaborar na resolução de conflitos
		❑ E. Modelar os comportamentos promovidos pelo projecto
		❑ F. Por em pratica leis que exigem as familias adoptem os comportamentos promovidos pelo projecto
		❑ G. Incentivar as Mães a procurar cuidados de saúde nas Uidades Sanitarias

		❑ H. Não ajudam em nada
		❑ I. Outros _____ _____
		❑ 99. Não sabe/Não Respondeu
20	Já alguma vez os Lideres comunitarios pediram incentivos pela particapação no projecto?	❑ 1. Sim
		❑ 2. Não ⇨⇨⇨ **Salte para Pergunta 22**
		❑ 99. Não sabe/Não Respondeu
21	Esses memmos Lideres que pediram incentivos continuam a colaborar com o procto mesmo sem receber os incentivos desejados?	❑ 1. Sim
		❑ 2. No
		❑ 99. Não sabe/Não Respondeu
22	Já alguma vez as MCs pediram incentivos pela particapação no projecto?	❑ 1. Sim
		❑ 2. Não ⇨⇨⇨ **Salte para Pergunta 24**
		❑ 99. Não sabe/Não Respondeu
23	Essas memmos MCs que pediram incentivos continuam a participar no procto mesmo sem receber os incentivos desejados?	❑ 1. Sim
		❑ 2. Nã0
		❑ 99. Não sabe/Não Respondeu
24	**Algumas Mães do projecto adoptaram bos praticas e outras não.**	❑ A. Mães desconheciam as boas praticas antes do projecto. Quando for a informadas elas passaram a adotar
		❑ B. Nivel social, economico e cultural da Mães

	Porque acha qua algumas Mães foram capazes de mudar suas praticas? *São premitidas Multiplas Respostas. Assinale todas as respostas dadas*	❑ C. Mães compreenderam que a mudança era importante, necessária e benéfica
		❑ D. Pra ajudar as outras na comunidade que resistem aos costumes culturais
		❑ E. Elas se preocupam com o bem estar de suas familias.
		❑ F. Outros _____
		❑ 99. Não sabe/Não Respondeu
25	Que mudanças tem visto em si mesmo como resultado deste procto? **Sondagem** *: Que habilidades você ganhou ao se tornar MC do projecto? São premitidas Multiplas Respostas. Assinale todas as respostas dadas*	❑ A. Adoptaram as praticas saudaveis que foram enisinadas
		❑ B. São mais capazes e confiantes para ensinar
		❑ C. Melhoraram habilidades de comunicação
		❑ D. Gained skills to produce reports, analyze data and interpret data
		❑ E. Ganharam habilidades de pesquisa
		❑ F. Aprenderam a escutar e respeitar as opinéos dos outros
		❑ G. Capazes de identificar sinais de perigo nas crianças e gravidas e dar o apropriado aconselhamento
		❑ H. Capazes de indentificar crianças com baixo peso e dar o aconselhamento aproriado
		❑ I. Capazes de dar aconselhamento sobre a saude da criança (como casos de diarrea pneumonia, malaria, etc..)
		❑ J. Capazes de aconselhar sobre amamentação excluisiva
		❑ L. Outros _____

		❑ 99. Não sabe/Não Respondeu
26	Algumas vez falou com o pessoal da Unidade Sanitaria acerca dos Tópicos ensinados pelo projecto?	❑ 1. Sim ❑ 2. Não ⇨⇨⇨ **Termine a Entrevista** ❑ 99. Não sabe/Não Respondeu
26	Nos ultimos 12 mesesIn the past 12 months, quantas vezes falou com o pessoal da Unidade Sanitaria em relação aos assuntos abordados pelo projecto? 1 Vez, 2 - 4 Vezes, 4 - 6 Vezes, 6 ou mais Vezes?	❑ 1. 1 Vez ❑ 2. 2 - 4 Vezes ❑ 3. 4 - 6 Vezes ❑ 4. 6 ou mais Vezes ❑ 5. Nunca ❑ 6. Outros _____ ❑ 99. Não sabe/Não Respondeu

ANNEX 6: KPC Questionnaire for BM English

Mother Beneficiary KPC

Interviewer needs 3 image sheets to complete this survey.

Unless indicated otherwise mark only one answer per question. DO NOT LEAVE ANY QUESTIONS BLANK!

Interviewer checks of ML is from a Phase I or Phase II District: Phase I is ML from Manga, Caia, Maringue, Chemba, or Marromeu Phase II is ML from Dondo, Nhamatanda, or Gorongosa	❑ 1. Phase I Mother Leader ❑ 2. Phase 2 Mother Leader

Number	Question	Response & Skip Pattern
1	How old are you? *Probe: How old were you at your last birthday?*	_____ Years ❑ 99. Not sure / No answer
2	Have you ever attended school or preschool?	❑ 1. Yes ❑ 2. No ⇨⇨⇨ **SKIP TO QUESTION 4**
3	How many years of school did you complete?	_____ Years ❑ 99. Not sure / No answer
4	How many years have you participated in the child survival project?	_____ Years ❑ 99. Not sure / No answer
5	Do you have a child that is < 2 years old?	❑ 1. Yes ❑ 2. No ❑ 3. Not sure/ Don't know
6	Are you currently pregnant?	❑ 1. Yes ❑ 2. No ❑ 3. Not sure / Don't know
7	Where did you have your last baby?	❑ 1. Hospital or health facility ❑ 2. My home or someone else's home ❑ 3. In transit to hospital

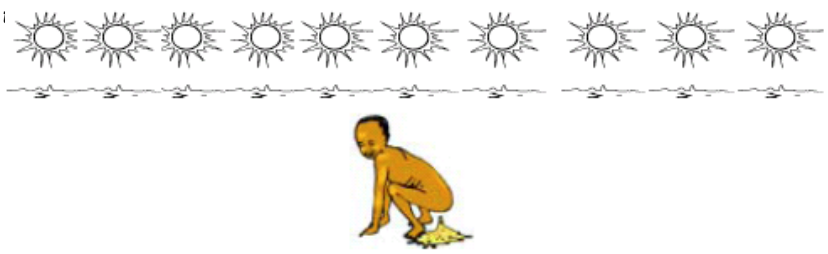
		❑ 5. Other _____ _____ ❑ 99. Not sure / Don't know
8	Did you have the same mother leaders throughout the course of the child survival project?	❑ 1. Yes ❑ 2. No ❑ 3. Not sure / Don't know
9	How many beneficiary mothers do your mother leaders teach? *(Have respondents estimate if not sure)*	_____ # of beneficiary mothers ❑ 99. Not sure / Don't know
10	How many beneficiary mothers are usually present at a group tea*ching session led by the mother leader?*	_____ # of beneficiary mothers ❑ 99. Not sure / Don't know
11	In the last 12 months, how many beneficiary mothers dropped out of your mother beneficiary Care group?	_____ # of mother beneficiaries ❑ 99. Not sure / Don't know
12	Why did the mother beneficaries drop out of the project? *Allow free answer, do not prompt. Mark all that apply.*	❑ 1. Lack of incentives ❑ 2. Moved to new areas ❑ 3. Too much time was spent reviewing topics they already knew. ❑ 4. Lack of interest ❑ 5. Replaced by the community or ML because not teaching other mothers ❑ 6. Busy working on farms ❑ 7. Other _____ ❑ 99. Not sure / Don't know
	Interviewer: Now I am going to ask you some questions about the use of flipcharts during the group sessions	
13	How often did your mother leaders share educational messages using the flipchart with you?	❑ 1. Once a week ❑ 2. Once every two weeks ❑ 3. Once a month ❑ 4. Once every two months

		❑ 5. Other _____ ❑ 6. Did not share messages with me ⇨⇨ **END OF SURVEY** ❑ 99. Not sure / Don't know
14	Did mother leaders share educational messages with you in a group meeting or through a home visit?	❑ 1. Only through group meetings ❑ 2. Mostly through group meetings and some home visits ❑ 3. Only through home visits ⇨⇨⇨ **SKIP TO #19** ❑ 4. Mostly through home visits and some group teaching ❑ 5. Other _____ ❑ 99. Not sure / Don't know
15	How long did it take you to walk to the group meetings led by the mother leaders?	_____ minutes ❑ 99. Not sure / Don't know
16	How long did the group meetings led by the mother leaders normally last?	❑ 1. Less than one hour ❑ 2. Between one to two hours ❑ 3. Two or more hours ❑ 5. Other _____ ❑ 99. Not sure / Don't know
17	Over the last 3 months how many group teaching sessions were you able to attend on average? *Prompt:* All meetings, most meetings, some meetings, a few meetings, or never able to attend?	❑ 1. All meetings (90% or more) ⇨⇨⇨ **SKIP TO #19** ❑ 2. Most meetings (75-89% or more) ❑ 3. Some meetings (40-74%) ❑ 4. A few meetings (<40%) ❑ 5. Never able to attend ❑ 99. Not sure / Don't know
18	When you missed a group teaching session what happened if anything?	❑ 1. Mother leader visited me at my home and shared the lesson ❑ 2. I visited the mother leader to receive the lesson ❑ 3. I caught up on the material in the next meeting

		❑ 4. I asked another mother beneficiary to explain the lesson to me ❑ 5. Nothing happened ❑ 6. Other _____ _____ ❑ 99. Not sure / Don't know
19	How long did the home visits made to you by the mother leader normally last?	❑ 1. Less than one hour ❑ 2. Between one to two hours ❑ 3. Two or more hours ❑ 5. Other _____ ❑ 88. Not applicable ❑ 99. Not sure / Don't know
20	When the mother leader shared flipchart lessons with you in your home did anyone else also listen? If yes, who?	❑ 1. No one else listened ❑ 2. Female children ❑ 3. Male children ❑ 4. Female relative ❑ 5. Male relative ❑ 6. Female friend ❑ 7. Male friend ❑ 8. Husband ❑ 88. Not applicable ❑ 99. Not sure / Don't know
21	Can you read the words on the flipchart?	❑ 1. Yes, I can read the words ❑ 2. No, I cannot read the words ❑ 3. I can read some but not all of the words ❑ 4. Other _____ _____

		❑ 99. Not sure / Don't know
22	When the mother leader shared the flipchart messages with you, did she do anything other than explain what the images meant?	❑ 1. Yes ❑ 2. No ⇨⇨⇨ **SKIP TO QUESTION 24** ❑ 3. Not sure / Don't know
23	What educational methods did she use in her presentations? *Do not prompt. Mark all that apply.*	❑ 1. Games ❑ 2. Stories ❑ 3. Demonstrations ❑ 4. Asked questions, led discussion or debate ❑ 5. Revision of previous session material ❑ 6. Asked beneficary mother to summarize material ❑ 7. Prayer ❑ 8. Other _____ _____ ❑ 99. Not sure / Don't know
24	Some mothers in the project adopted good practices and others did not. Why do you think some mothers were able to change their practices? *Do not prompt. Mark all that apply.*	❑ 1. Mothers were unaware of good practices before the project. When they were made aware they adopted them. ❑ 2. Social, economic, and culture level of Mothers ❑ 3. They understood that the change was important, necessary, and beneficial ❑ 4. To support others in the community who resist cultural customs ❑ 5. They were concerned for the welfare of their family. ❑ 6. Other _____ ❑ 99. Not sure / Don't know
25	What changes have you made in your home as a result of this project? *Do not prompt. Mark all that apply.*	❑ 1. Adopted the healthy nutrition practices ❑ 1. Adopted the healthy hygiene and sanitation practices ❑ 2. More capable and confident to teach (using flipchart)

		❑ 3. Able to identify danger signs in children and pregnant women and counsel appropriately ❑ 4. Able to identify when a child is underweight and counsel appropriately ❑ 5. Able to give advice on child illnesses (like diarrhoea, pneumonia, malaria, etc..) ❑ 6. Able to counsel on appropriate breastfeeding ❑ 7. Other _____ _____ ❑ 99. Not sure / Don't know
	Interviewer: Now I am going to ask you about taking care of your child.	
25	At what age should you start giving your infant water, tea, or porridge?	_____ months of age ❑ 99. Not sure / Don't know
26	How many times have you visited a healthcare facility in the last 12 months?	_____ times a year ❑ 99. Not sure / Don't know
26	What are danger signs that indicate a child needs to go immediately to the health post? *Prompt:* Are there any other signs? *Keep asking for more signs or symptoms until the mother cannot recall any additional danger signs* *Circle all signs mentioned, but do NOT prompt with any suggestions*	❑ 1. Diarreia sanguinolenta ❑ 2. Recusa consumir liquidos e solidos ❑ 3. Fraca ou letargica, nao conseque acordar ❑ 4. Diarreia ha duas semanas ❑ 5. Febre alta ❑ 6. Convultions ❑ 7. Vomiting ❑ 8. Other _____ _____ ❑ 99. Not sure / Don't know
27	When should you wash your hands with soap or ash? *Prompt:* Are there any other situations? *Keep asking for more instances until the mother cannot recall any additional times*	❑ 1.Usar ou limpar a latrina ❑ 2. Limpar o nus da crianca ou assoar o nariz ❑ 3. Quiser preparar a comida

	Circle all instances mentioned, but do NOT prompt with any suggestions	❑ 4. Quiser preparar qualquer alimento ou dar de comer as criancas. ❑ 5. Other _____ _____ ❑ 99. Not sure / Don't know
	Now I am going to show you some pictures and ask you a few questions about them	
28	What is the key message this image is meant to convey? ***Enumerator should have a large size picture of*** 	o é uma emergencia _____ _____
29	What is the key message this image is meant to convey? ***Enumerator should have a large size picture of the image below to show to the MB.*** 	❑ 1. ALEITAMENTO como prevenção da Malnutrição e outras doenças ❑ 2. Other incorrect message ❑ 3. Other correct message:_____ _____ ❑ 99. Not sure / Don't know
30	What is the key message this image is meant to convey? ***Enumerator should have a large size picture of the image below to show to the MB***. 	❑ 1. Tomar medicamento (desparisantes) de 6 em 6 meses depois fazer 1 ano de idade. ❑ 2. Other incorrect message ❑ 3. Other correct message:_____ _____

		❑ 99. Not sure / Don't know
31	Voce acredita que vale mais o homen que a mulher, vale mais a mulher que a homen, ou sao iguais ?	❑ 1. Homen vale mais ❑ 2. Mulher vale mais ❑ 3. Sao Iguais ❑ 99. Nao sabe/ Nenhuma Reposta
32	Is it okay for a husband to hit his wife if he is unhappy with her?	❑ 1. Yes ❑ 2. No ❑ 99. Not sure / Don't know

ANNEX 7: KPC Questionnaire for LM English

Mother Leader KPC

Interviewer needs 3 image sheets to complete this survey.

Unless indicated otherwise mark only one answer per question. DO NOT LEAVE ANY QUESTIONS BLANK!

Interviewer checks of MB is from a Phase I or Phase II District:	❑ 1. Phase I Mother Beneficiary
Phase I is MB from Manga, Caia, Maringue, Chemba, or Marromeu Phase II is MB from Dondo, Nhamatanda, or Gorongosa	❑ 2. Phase 2 Mother Beneficiary

#	Question	Response & Skip Pattern

1	How old are you? *Probe: How old were you at your last birthday?*	_____ Years
2	Have you ever attended school or preschool?	❑ 1.Yes ❑ 2. No ⇨⇨⇨ **SKIP TO QUESTION 4**
3	How many years of school did you complete?	_____ Years
4	How many years have you been a mother leader for the child survival project?	_____ Years
5	Do you have a child that is < 2 years old?	❑ 1. Yes ❑ 2. No ❑ 3. Not sure / No answer
6	Are you currently pregnant?	❑ 1. Yes ❑ 2. No ❑ 3. Not sure / No answer
	Interviewer: Now I am going to ask you some questions about your experience with the child survival project	
8	How were you selected to be a mother leader?	❑ 1. Elected by other mothers in group ❑ 2. Invited to be a mother leader by Community Leaders ❑ 3. Invited to be a mother leader by FH Promoter ❑ 4. Other _____ _____ ❑ 99. Not sure / Don't know
9	To the best of your knowledge how many mother leaders are registered in your mother leader group that is led by the promoter at present?	_____ # of ML ❑ 99. Not sure / Don't know
10	On average over the last 3 months, how many mother leaders are actually present at a group teaching session led by the Promoter?	_____ # of ML ❑ 99. Not sure / Don't know
11	Over the last 12 months how many mother leaders dropped out of your mother leader group that was led by a Promotor?	_____ # of ML per ML group ❑ 99. Not sure / Don't know
12	In your opinion, why did the mother leaders drop out	❑ 1. Lack of incentives

	of the project? *Allow respondent to freely answer, do not prompt. Mark all that apply.*	❑ 2. Moved to a new area ❑ 3. Too much time was spent reviewing topics they already knew ❑ 4. Lack of interest ❑ 5. Replaced by the community or promoter because not teaching other mothers ❑ 6. Busy working on farms ❑ 7. Other _____ _____ ❑ 99. Not sure / Don't know
11	Over the last 3 months, how many promoter led meetings were you able to attend? *Prompt:* All meetings, most meetings, some meetings, a few meetings, or never able to attend?	❑ 1. All meetings (>90%) ⇨⇨ **SKIP TO QUESTION 13** ❑ 2. Most meetings (75-89% or more) ❑ 3. Some meetings (40-74%) ❑ 4. A few meetings (<40%) ❑ 5. Never able to attend ❑ 99. Not sure / Don't know
12	When you missed a promoter led meeting what happened if anything?	❑ 1. Promoter visited me at home and shared the lesson ❑ 2. I visited the promoter to receive the lesson ❑ 3. I caught up on the material in the next meeting ❑ 4. I asked another mother to explain the lesson to me ❑ 5. Nothing happened ❑ 6. Other _____ _____ ❑ 99. Not sure / Don't know
13	How long did it take you to walk to the promoter led meetings?	_____ ___ minutes ❑ 99. Not sure / Don't know
	Interviewer: Now I am going to ask you some questions about your experience with using flipcharts in this program	

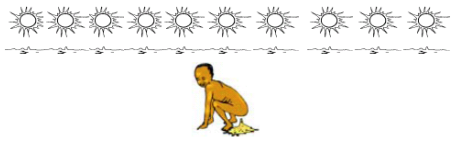
14	How often did you meet with the Promoter to receive a flipchart lesson?	❑ 1. Once a week ❑ 2. Once every two weeks ❑ 3. Once a month ❑ 4. Once every two months ❑ 5. Other _____ ❑ 6. Have never met with promotor ❑ 99. Not sure / Don't know
15	When teaching from the flipchart do you read the printed words to help you remember the messages?	❑ 1. Yes, I read the printed words ❑ 2. No, I do not read the printed words ❑ 3. I read some of the words but mostly use the images ❑ 4. Other _____ _____ ❑ 99. Not sure / Don't know
16	How many mothers did you share the flipchart messages with if any?	_____ # of MB ❑ 99. Not sure / Don't know
17	How often did you share flipchart messages with beneficiary mothers?	❑ 1. Once a week ❑ 2. Once every two weeks ❑ 3. Once a month ❑ 4. Once every two months ❑ 5. Other _____ ❑ 99. Not sure / Don't know
18	When teaching mother beneficiaries, what type of educational methods do you use other than explaining the images on the flipchart? *Allow free answers only, do not prompt. Mark all that apply*	❑ 1. Games ❑ 2. Stories ❑ 3. Demonstrations ❑ 4. Explanation of images ❑ 5. Discussion Questions ❑ 6. Other _____

		_____ ❑ 99. Not sure / Don't know
19	Did you normally share flipchart messages with beneficiary mothers in a group setting or through home visits?	❑ 1. Only through group teaching sessions ❑ 2. Mostly through group teaching. Did home visits only to mothers who missed the group teaching session ❑ 3. Only through home visits ❑ 4. Mostly through home visits and some group teaching ❑ 5. Other _____ ❑ 99. Not sure / Don't know
20	How long did it take you to walk to your closest mother beneficiary's house?	_____ ___ minutes q 99. Not sure / Don't know
21	How long did it take you to walk to your farthest mother beneficiary's house?	_____ ___ minutes q 99. Not sure / Don't know
22	How long did the group meetings you held with the beneficiary mothers normally last?	❑ 1. Less than one hour ❑ 2. One and a half hours ❑ 3. Two hours ❑ 4. More than two hours ❑ 5. Other _____ ❑ 99. Not sure / Don't know
23	How long did the home visits you made to beneficiary mothers normally last?	❑ 1. Less than one hour ❑ 2. Between one to two hours ❑ 3. Two or more hours ❑ 5. Other _____ ❑99. Not sure / Don't know
	Interviewer: Now I am going to ask you a few questions about Community leaders and their role in the child survival project	
24	Over the last 12 months, how often did you meet with Community Leaders to talk about the child survival	❑ 1. Once or more a month ❑ 2. Once every two months

	project?	❑ 3. Once every three months ❑ 4. Once every six months ❑ 5. Once a year ❑ 6. Never ❑ 99. Not sure / Don't know
25	How did community leaders support the child survival project? *Allow free answers only, do not prompt. Mark all that apply.*	❑ 1. Encouraged mother leaders and mother beneficiaries to participate in group teaching ❑ 2. Encouraged mother leaders and mother beneficiaries to put into practice the teachings they received ❑ 3. Helped explain the project to mother leaders and beneficiaries ❑ 4. Assisted in conflict resolution ❑ 5. Modeled behaviors promoted by child survival project ❑ 6. Put laws into place that require families to adopt child survival behaviors ❑ 7. Helped mothers to seek health care at the health post ❑ 8. Did not help ❑ 9. Other _____ ❑ 99. Not sure / Don't know
	Interviewer: Now I am going to ask you some questions about being a mother leader	
26	In your opinion, have people in your community given you more respect because you are a mother leader?	❑ 1. Yes ❑ 2. No ⇨⇨⇨ **SKIP TO #31** ❑ 3. Not sure / No answer
27	Who respects you now that did not before you became a mother leader? *Allow free answer, do not prompt. Mark all that apply.*	❑ 1. Husband ❑ 2. Parents or husband's parents ❑ 3. Community leaders ❑ 4. Other mothers / women ❑ 5. Extended family (Grandparents, Aunt, Uncle, Cousin, etc..) ❑ 6. Health facility personnel

		❑ 7. Other _____ ❑ 99. Not sure / Don't know
28	Some mothers in the project adopted good practices and others did not. Why do you think some mothers were able to change their practices? *Allow free answer, do not prompt. Mark all that apply.*	❑ 1. Mothers were unaware of good practices before the project. When they were made aware they adopted them. ❑ 2. Social, economic, and culture level of Mothers ❑ 3. They understood that the change was important, necessary, and beneficial ❑ 4. To support others in the community who resist cultural customs ❑ 5. They were concerned for the welfare of their family. ❑ 6. Other _____ ❑ 99. Not sure / Don't know
29	What changes have you seen in yourself as a result of this project? *Probe:* What skills have you gained from being a mother leader in this project? *Allow free answer, do not prompt. Mark all that apply.*	❑ 1. Adopted healthy nutrition practices ❑ 1. Adopted healthy hygiene and sanitation practices ❑ 2. More capable and confident to teach (using flipchart) ❑ 3. Able to identify danger signs in children and pregnant women and counsel appropriately ❑ 4. Able to identify when a child is underweight and counsel appropriately ❑ 5. Able to give advice on child illnesses (like diarrhoea, pneumonia, malaria, etc..) ❑ 6. Able to counsel on appropriate breastfeeding ❑ 7. Other _____ _____ ❑ 99. Not sure / Don't know
30	In the past 12 months, how many times have you talked to health facility staff regarding subjects that you talked about in this child survival project? One time, two to four times, four to six times, or six or more times?	❑ 1. One time ❑ 2. Two to four times ❑ 3. Four to six times ❑ 4. Six or more times

		❑ 5. Never ❑ 6. Other _____ _____ ❑ 99. Not sure / Don't know
	Interviewer: Now I am going to ask you some questions about caring for your child and handwashing	
31	At what age should you start giving your infant water, tea, or porridge?	_____ months old ❑ 99. Not sure / Don't know
32	What are danger signs that indicate a child needs to go immediately to the health post? *Prompt:* Are there any other signs? *Keep asking for more signs or symptoms until the mother cannot recall any additional danger signs* *Circle all signs mentioned, but do NOT prompt with any suggestions*	❑ 1. Diarreia sanguinolenta ❑ 2. Recusa consumir liquidos e solidos ❑ 3. Fraca ou letargica, nao conseque acordar ❑ 4. Diarreia ha duas semanas ❑ 5. Febre alta ❑ 6. Convulsions ❑ 7. Vomiting ❑ 8. Other _____ _____ ❑ 99. Not sure/Don't know
33	When should you wash your hands with soap or ash? *Prompt:* Are there any other situations? *Keep asking for more instances until the mother cannot recall any additional times* *Circle all instances mentioned, but do NOT prompt with any suggestions*	❑ 1. Usar ou limpar a latrina ❑ 2. Limpar o nus da crianca ou assoar o nariz ❑ 3. Quiser preparar a comida ❑ 4. Quiser preparar qualquer alimento ou dar de comer as criancas. ❑ 5. Other _____ _____ ❑ 99. Not sure / Don't know
37	Voce acredita que vale mais o homen que a mulher, vale mais a mulher que a homen, ou sao iguais ?	❑ 1. Homen vale mais ❑ 2. Mulher vale mais

		❑ 3. Sao Iguais ❑ 99. Nao sabe/ Nenhuma Reposta
38	Is it okay for a husband to hit his wife if he is unhappy with her?	❑ 1. Yes ❑ 2. No ❑ 99. Not sure / Don't know
	Interviewer: Now I am going to show you some pictures and ask you a few questions about them	
34	What is the key message this image is meant to convey? *Enumerator should have a large size picture of the image below to show to the mother* 	❑ 1. Diarreia há duas semanas – isto é uma emergencia ❑ 2. Other incorrect message ❑ 3. Other correct message:_____ _____ ❑ 99. Not sure / Don't know □
35	What is the key message this image is meant to convey? *Enumerator should have a large size picture of the image below to show to the mother* 	❑ 1. ALEITAMENTO como prevenção da Malnutrição e outras doenças ❑ 2. Other incorrect message ❑ 3. Other correct message:_____ _____ ❑ 99. Not sure / Don't know
36	What is the key message this image is meant to convey? *Enumerator should have a large size picture of the image below to show to the mother* 	❑ 1. Tomar medicamento (desparisantes) de 6 em 6 meses depois fazer 1 ano de idade. ❑ 2. Other incorrect message ❑ 3. Other correct message:_____ _____

		❑ 99. Not sure / Don't know

PROMOTER KPC

Unless indicated otherwise mark only one answer per question. DO NOT LEAVE ANY QUESTIONS BLANK!

Interviewer checks of MB is from a Phase I or Phase II District: Phase I is Promoter from Manga, Caia, Maringue, Chemba, or Marromeu Phase II is Promoter from Dondo, Nhamatanda, or Gorongosa	❑ 1. Phase I Promoter ❑ 2. Phase 2 Promoter

No.	Question	Response
1	Are you male or female?	❑ 1. Female ❑ 2.Male
2	How old are you? *Probe:* How old were you at your last birthday?	_____ Years
3	Have you ever attended school or preschool?	❑ 1.Yes ❑ 2. No ⇨⇨⇨ **SKIP TO QUESTION 5**
4	How many years of school have you completed?	_____ Years
5	How many years have you worked for Food for the Hungry as a Child Survival Facilitator?	_____ Years
6	Are you a Phase I or Phase II Facilitator for the Child Survival project?	❑ 1. Phase I ❑ 2. Phase II ❑ 99. Not sure / Don't know
7	Before starting work in the community you work in, were you a resident of that community for at least three years?	❑ 1. Yes ❑ 2. No ❑ 99. Not sure / Don't know

	Now I am going to ask you questions about the mother leader groups that you teach.	
8	On average, how many mother leaders are registered in your mother leader groups?	_____ # of ML
9	On average, how many mother leaders are present at each group teaching session?	_____ # of ML
10	How long did the group meetings you held with the leader mothers normally last?	❑ 1. Less than one hour ❑ 2. One and a half hours ❑ 3. Two hours ❑ 4. More than two hours ❑ 5. Other _____ ❑99. Not sure / Don't know
11a	On average, how many mother leaders miss the group lesson?	_____ # of ML who miss the group lesson
11b	On average, how many women do you visit in their homes because they missed the group lesson in a two week period?	_____ # of home visits per month
12	On average how many mother leaders dropped out of the program per group of mother leaders in the last 12 months?	_____ # of mother leaders per mother leader group If 00 aaa SKIP TO QUESTION 13
13	Why did mother leaders drop out of the project? *Allow respondant to freely answer, do not prompt. Mark all that apply.*	❑ 1. Lack of incentives ❑ 2. Moved to a new area ❑ 3. Too much time was spent reviewing topics they already knew ❑ 4. Lack of interest ❑ 5. Replaced by the community or promoter because not teaching other mothers ❑ 6. Busy working on farms ❑ 7. Other _____

		_____ ❑ 99. Not sure / Don't know
14	How many mother leaders in your mother leader groups share the lessons they received with ALL their beneficiary mothers? All, some, a few or none?	❑ 1. All (90% or more) ❑ 2. Most (75-89% or more) ❑ 3. Some (40-74%) ❑ 4. A few (<40%) ❑ 5. None ❑ 99. Not sure / Don't know
15	How many mother leaders in your mother leader groups are able to read the words on the flipchart? All, most, some, a few, or none?	❑ 1. All (90% or more) ❑ 2. Most (75-89% or more) ❑ 3. Some (40-74%) ❑ 4. A few (<40%) ❑ 5. None ❑ 99. Not sure / Don't know
16	D0 you use the flipchart lesson plan before or during a teaching session for mother leaders	❑ 1. Yes ❑ 2. No ❑ 99. Not sure / Don't know
17	What type of educational methods do you use when teaching mother leaders? *Allow free answers only, do not prompt. Mark all that apply*	❑ 1. Games ❑ 2. Stories ❑ 3. Demonstrations ❑ 4. Explanation of images ❑ 5. Discussion Questions ❑ 6. Other _____ _____ ❑ 99. Not sure / Don't know
	Now I am going to ask you questions about community leaders in the child survival project	
18	How many times have you met	❑ 1. 1-3 times

	with Community Leaders in the last 3 months?	❑ 2. 4-6 times ❑ 3. 7-9 times ❑ 4. 10 or more times ❑ 5. Never ❑ 99. Not sure / Don't know
19	How did community leaders support the child survival project? *Allow free answers only, do not prompt. Mark all that apply.*	❑ 1. Encouraged mother leaders and mother beneficiaries to participate in group teaching ❑ 2. Encouraged mother leaders and mother beneficiaries to put into practice the teachings they received ❑ 3. Helped explain the project to mother leaders and beneficiaries ❑ 4. Assisted in conflict resolution ❑ 5. Modeled behaviors promoted by child survival project ❑ 6. Put laws into place that require families to adopt child survival behaviors ❑ 7. Helped mothers to seek health care at the health post ❑ 8. Did not help ❑ 9. Other _____ ❑ 99. Not sure / Don't know
20	Has a community leader ever asked for incentives from the Child Survival project?	❑ 1. Yes ❑ 2. No ⇨⇨⇨ **SKIP TO QUESTION 22** ❑ 99. Not sure / Don't know
21	Did the same community leaders who asked for incentives continue to support the child survival project with their leadership, even though no incentives were provided?	❑ 1. Yes ❑ 2. No ❑ 99. Not sure / Don't know
22	Has a Mother Leader ever asked for incentives from the child	❑ 1. Yes ❑ 2. No ⇨⇨⇨ **SKIP TO QUESTION 24**

	survival project?	❑ 99. Not sure / Don't know
23	Did the same Mother Leaders who asked for incentives continue to volunteer as mother leaders in the child survival project, even though no incentives were provided?	❑ 1. Yes ❑ 2. No ❑ 99. Not sure / Don't know
24	Some mothers in the project adopted good practices and others did not. Why do you think some mothers were able to change their practices? *Allow free answer, do not prompt. Mark all that apply.*	❑ 1. Mothers were unaware of good practices before the project. When they were made aware they adopted them. ❑ 2. Social, economic, and culture level of Mothers ❑ 3. They understood that the change was important, necessary, and beneficial ❑ 4. To support others in the community who resist cultural customs ❑ 5. They were concerned for the welfare of their family. ❑ 6. Other _____ ❑ 99. Not sure / Don't know
25	What changes have you seen in yourself as a result of this project? *Probe:* What skills have you gained from being a mother leader in this project? *Allow free answer, do not prompt. Mark all that apply.*	❑ 1. Adopted the healthy practices that were taught ❑ 2. More capable and confident to teach ❑ 3. Improved communication skills ❑ 4. Gained skills to produce reports, analyze data and interpret data ❑ 5. Gained survey skills ❑ 6. Learned to listen and respect various opinions ❑ 7. Able to identify danger signs in children and pregnant women and counsel appropriately ❑ 8. Able to identify when a child is underweight and counsel appropriately ❑ 9. Able to give advice on child illnesses (like diarrhoea, pneumonia, malaria, etc..) ❑ 10. Able to counsel on appropriate breastfeeding ❑ 11. Other _____

		_____ _____ ❑ 99. Not sure / Don't know
26	Have you ever talked to health facility staff regarding subjects that you taught in this child survival project?	❑ 1. Yes ❑ 2. No ⇨⇨⇨ **END OF SURVEY** ❑ 3. Not sure/ Don't know
26	In the past 12 months, how many times have you talked to health facility staff regarding subjects that you talked about in this child survival project? One time, two to four times, four to six times, or six or more times?	❑ 1. One time ❑ 2. Two to four times ❑ 3. Four to six times ❑ 4. Six or more times ❑ 5. Never ❑ 6. Other _____ _____ ❑ 99. Not sure / Don't know

ANNEX 9: RESULTS TABLE FOR OR KPC SURVEY

Results of the Mozambique Expanded Impact Child Survival Project Care Group Operational Research

May 2010 Sofala Mozambique

Indicators or Information measured in the Care Group KPC	Mother Beneficiary			Mother Leader			Promoter		
	Phase I	Phase II	Phase I&II	Phase I	Phase II	Phase I&II	Phase I	Phase II	Phase I&II
Number of Respondents to Survey Questions	101	99	**200**	100	100	**200**	25	35	**60**
% who ever Attended School	60.4%	56.6%	**58.5%**	54.0%	71.0%	**63.0%**	100.0%	100.0%	**100.0%**
Average years of education	5.1	5.2	**5.1**	4.9	4.7	**5.4**	10.5	9.2	**9.7**
% Able to read words on Flipcharts	29%	21%	**25%**	18%	24%	**21%**	44%	11%	**25%**
Average Age	29.7	26.2	**27.9**	41.2	33.7	**37.4**	31.1	28.9	**29.8**
Average Number of Years Involved in CS project	3.3	1.4	**2.4**	4.2	1.6	**2.9**	4.2	1.5	**2.67**
% who have children < 2 years of age or are pregnant	95%	97%	**96%**	36%	50%	**43%**	NA	NA	**NA**
% who are Female	100%	100%	**100%**	100%	100%	**100%**	28%	20%	**23%**
% Who had their last child in a health facility	9%	15%	**12%**	NA	NA	**NA**	NA	NA	**NA**
Average # of MB present at a ML teaching session	9.2	10.1	**9.7**	NA	NA	**NA**	NA	NA	**NA**
Average # of MB registered in the ML group	11.6	12	**11.7**	9.6	10.6	**9.8**	NA	NA	**NA**

Average # of ML present at a Promoter teaching session	NA	NA	**NA**	10.5	11	**10.7**	13.1	12.2	**12.6**
Average # of ML registered in the Promoter group	NA	NA	**NA**	12	11.8	**11.9**	NA	NA	**NA**
Average # of MB who dropped out of MB groups over the course of a year	2.4	0.6	**1.6**	1.2	0.7	**0.95**	NA	NA	**NA**
% turnover of ML in a 12 month period	6%	3%	**5%**	10%	6%	**8%**	NA	NA	**NA**
% turnover of Promoter over the LOA	NA	NA	**NA**	NA	NA	**NA**	16.0%	9.0%	**12.0%**
Top 3 reasons ML or MB dropped out of project	**1. Moved to new areas (34%), 2. Busy working (20%), 3. Lack of incentives (11%)**			**1. Moved to new areas (30%), 2. Busy working (16%), 3. Lack of incentives (13%)**			**1 Moved to new area (55%), 2 Lack of incentives (18%), 3 Busy working (13%)**		
% of ML who shared messages mostly or only through group meetings	70%	80%	**75%**	70%	71%	**70%**	NA	NA	**NA**
% of ML who shared messages mostly or only through home visits	30%	20%	**25%**	30%	29%	**30%**	NA	NA	**NA**
% of ML or MB that met every two weeks for health education and behavior change	95%	97%	**96%**	96%	100%	**98%**	92%	80%	**85%**
% of ML or MB that report attending most or all education sessions	73%	84%	**78%**	85%	82%	**84%**	NA	NA	**NA**
Average time traveled between ML and MB household	12 min	14 min	**13 min**	14min	17 min	**16 min**	NA	NA	**NA**
Average time traveled between Promoter and ML household	NA	NA	**NA**	17 min	16 min	**17 min**	NA	NA	**NA**
% of ML reported to have group meetings that lasted at least one hour	83%	71%	**77%**	78%	87%	**82%**	NA	NA	**NA**
% of ML reported to have made home visits that lasted less than one hour / one hour or more	58% / 39%	66% / 29%	**62% / 34%**	65% / 33%	71% / 25%	**68% / 29%**	NA	NA	**NA**
% of ML who when missed a lesson received the information	83%	71%	**77%**	98%	100%	**99%**	NA	NA	**NA**

Who else listened with a home visit was done:									
No one	20%	23%	**22%**	NA	NA	**NA**	NA	NA	**NA**
Daughter	50%	48%	**49%**	NA	NA	**NA**	NA	NA	**NA**
Son	5%	1%	**3%**	NA	NA	**NA**	NA	NA	**NA**
Mother	11%	10%	**11%**	NA	NA	**NA**	NA	NA	**NA**
Father	1%	3%	**2%**	NA	NA	**NA**	NA	NA	**NA**
Husband	0%	1%	**1%**	NA	NA	**NA**	NA	NA	**NA**
Female Friend	14%	14%	**14%**	NA	NA	**NA**	NA	NA	**NA**
ML used diverse educational methods to share Flipchart messages (games, stories, demonstrations, discussion, review, participant participation, and prayer)	14%	12%	**13%**	67%	80%	**74%**	56%	89%	**75%**
ML used Games	34%	48%	**41%**	67%	80%	**74%**	32%	29%	**30%**
ML used Stories	37%	49%	**43%**	14%	13%	**14%**	20%	29%	**25%**
ML used Demonstrations	49%	45%	**47%**	20%	28%	**24%**	8%	43%	**28%**
ML reviewed the previous sessions material	46%	46%	**46%**	49%	60%	**55%**	60%	83%	**73%**
ML asked participants to summarize the material	48%	49%	**49%**	90%	89%	**90%**	16%	60%	**42%**
ML used prayer	24%	26%	**25%**	NA	NA	**NA**	NA	NA	**NA**
MB or ML that know 6m is the age that an infant should be given water, tea, or food	89%	89%	**89%**	73%	90%	**82%**	NA	NA	**NA**

MB or ML can mention 3 or more child danger signs	67%	73%	**70%**	61%	87%	**74%**	NA	NA	**NA**
ML can mention 2 or more appropriate times to wash hands	98%	97%	**97%**	96%	100%	**98%**	NA	NA	**NA**
Average number of times MB or ML went to the hospital in the lsat 12m	6.8	6.6	**6.7**	NA	NA	**NA**	NA	NA	**NA**
% of MB or ML who could correctly state the key message associated with a flipchart image	51%	52%	**52%**	50%	49%	**50%**	NA	NA	**NA**
% of MB or ML who believe men and women have equal value	11%	20%	**16%**	43%	46%	**45%**	NA	NA	**NA**
% of MB or ML who believe that spousal abuse is acceptable	43%	25%	**34%**	95%	99%	**97%**	NA	NA	**NA**
% of ML who were elected by other mothers to be the ML	NA	NA	**NA**	50%	37%	**44%**	NA	NA	**NA**
% of ML who were invited by CL or Promoters	NA	NA	**NA**	47%	63%	**55%**	NA	NA	**NA**
% of ML or Promoter who met with Community Leader at least once every 6 months	NA	NA	**NA**	77%	72%	**75%**	96%	100%	**98%**
The top 3 ways Community Leader assisted the CS Project	NA	NA	**NA**	Encouraged the ML and the MB to participate in the group teachings, helped to explain the projec to the ML and MB, and encouraged the ML and MB to practice the teachings they received.			Encouraged the ML and the MB to participate in the group teachings, collaborated in the resolution of conflicts, helped to explain the project to the ML and MB		
% of Community Leader who asked for incentives but continued supporting the project	NA	NA	**NA**	NA	NA	**NA**	100%	100%	**100%**
% of ML who asked for incentives but continued volunteering in the project	NA	NA	**NA**	NA	NA	**NA**	93%	100%	**100%**
% of ML who have gained respect from their husbands	NA	NA	**NA**	65%	57%	**61%**	NA	NA	**NA**

% of ML who have gained respect from theirparents or husbands parents	NA	NA	**NA**	39%	57%	**48%**	NA	NA	**NA**
% of ML who have gained respect from theircommunity leaders	NA	NA	**NA**	60%	68%	**64%**	NA	NA	**NA**
% of ML who have gained respect from their mothers / other women / mother beneficiaries	NA	NA	**NA**	100%	100%	**100%**	NA	NA	**NA**
% of ML who have gained respect from their extended family	NA	NA	**NA**	29%	52%	**41%**	NA	NA	**NA**
% of ML who have gained respect from health facility personnel	NA	NA	**NA**	28%	22%	**25%**	NA	NA	**NA**
ML who communicated with health facility staff at least 1 time in the last six months about CS topics or activities	NA	NA	**NA**	67%	62%	**65%**	NA	NA	**NA**
Promoters who communicated with health facility staff at least 4 times in the last six months about CS topics or activities	NA	NA	**NA**	NA	NA	**NA**	52%	63%	**58%**
Promoters who used the Flipchart lesson plan before or during CG teaching	NA	NA	**NA**	NA	NA	**NA**	96%	100%	**98%**

Acronyms: CG = Care Group CS = Child Survival ML = Mother Leader MB = Mother Beneficiary NA = Not Applicable LOA = Length of Activity

Annex 19: Project Data Form

Child Survival and Health Grants Program Project Summary

Dec-27-2010

Food For The Hungry, International (Mozambique)

General Project Information

Cooperative Agreement Number:	GHS-A-00-05-00014
FH Headquarters Technical Backstop:	Carolyn Wetzel
FH Headquarters Technical Backstop Backup:	Tom Davis
Field Program Manager:	Emma Hernandez
Midterm Evaluator:	Donald Whitson
Final Evaluator:	Henry Perry
Headquarter Financial Contact:	Glenda Herring
Project Dates:	9/30/2005 - 12/31/2010 (FY05)
Project Type:	Expanded Impact
USAID Mission Contact:	Jeri Dible
Project Web Site:	na

Field Program Manager

Name:	Emma Hernandez (Child Survival Mgr.)
Address:	Rue Martires de Massangano, No. 557 Beira Mozambique
Phone:	258 23 320 595
Fax:	258 23 320 587
E-mail:	ehernandez@fh.org
Skype Name:	

Alternate Field Contact

Name:	Maparura Nkwelimba (Country Director)
Address:	Maputo Mozambique
Phone:	258 23 320 595
Fax:	258 23 320 587
E-mail:	mnkwelimba@fh.org
Skype Name:	

Grant Funding Information

USAID Funding: $2,699,910 **PVO Match:** $847,653

General Project Description

Mozambique ranks 168th out of 177 countries in terms of poverty (2005 UNDP Human Development Report) and currently 70% of the population of Sofala province lives on less than $1 per day. The under-five mortality rate (U5MR) for Sofala is 205 compared with 178 nationally and the infant mortality rate (IMR) is 149 (cf. 124 nationally). In addition, 42.3% of children 0-59m of age in Sofala province are stunted (HAZ<-2); 7.6% are wasted (WHZ<-2); and 26.2% are underweight (WAZ<-2). Forty-four percent of all deaths in Mozambique are malnutrition related. Maternal nutritional practices in Sofala are poor. The percentage of children exclusively breastfed in project districts is only 17%. Feeding frequency and nutrient-density of foods given to children are both problematic. Only one-third of children in project districts (9-23m of age) receive three or more feedings per day apart from breastfeeding. Behavior related to diarrhea is also quite poor: while 90% of mothers in project districts have heard about ORS, only 44 % of mothers can correctly prepare ORS from packets. To improve the health and nutritional status of children in Sofala, Food for the Hungry (FH) will implement a five-year (October 1, 2005- September 31, 2010) $3.3 million , Expanded Impact Child Survival Project utilizing the Care Group (CG) model. This project will expand FH's successful Care Group model into ten districts in Sofala province. The CG methodology helps mothers to learn how to help their children survive and thrive, and to adopt new behaviors. In FH's methodology, an initial census is done to divide households with children under two years of age or pregnant women into groups of twelve. Each twelve-household group elects a LM under the guidance of the Promoter. A group of 14 LMs forms a Care Group. Each Promoter serves five Care Groups, and meets with the LMs in each Care Group every two weeks for two hours. During Care Group meetings, Promoters teach LMs weekly health messages using small flipcharts and other educational materials and methods. LMs discuss the health lessons, report on illnesses of children in the households they serve, discuss problem cases (e.g., in terms of behavior change), and report on vital events. LMs practice health promotion in pairs, and are supervised and coached by the Promoter. During the two weeks between Care Group meetings, each of the 4,830 LMs does health promotion through home visits to each of the twelve women/mothers that she serves (households with pregnant women or children under two). Children 24-59m of age are seen every six months and receive vitamin A, deworming drugs, and are screened for malnutrition. Complimenting the work that has already been carried out by the MOH and other partners in clinical IMCI, all 69 Promoters and one Leader Mother per Care Group (345) will receive training in community and household IMCI, and learn to assess, classify, refer, and provide advice on home management to mothers in the communities where they work. FH and its partners in Sofala will jointly conduct training and supervision of Promoters to ensure that the partners can continue maintaining the structure once the project has ended. FH has demonstrated this model to have a positive impact on malnutrition, mortality and results-level indicators of preschool children in Mozambique, as well as changes in maternal morbidity. During the period 1998 to 2001, FH/M decreased malnutrition by 40% (from 50.4% to 30.3%, p<0.05) with consonant, dramatic changes in mothers' nutritional and other health practices using this model. Preliminary results of a mortality study conducted in conjunction with World Relief and with the support of John Hopkins in 2004 found that the U5MR dropped by 62% (from 107/1000 to 41/1000), between 1999 and 2003 in areas where FH has used the Care Group approach in Sofala province. The IMR decreased from 66 to 38 (42%) in the same areas. The goals of this expanded impact program are to (1) significantly reduce morbidity and mortality – especially among children 0-23m of age and pregnant women – in Sofala province; (2) increase access to community and household IMCI-trained health providers in the program areas; and (3) to transfer the knowledge, skills, tools, and passion needed for effective and sustainable community health development through the Care Group model to project partners – including Leader Mothers – in order to continue child survival activities once this project has ended. FH estimates the beneficiary population to be 198,594 people. This included 21,521 pregnant women, 42,927, and 134,146 children: 26,829 infants. FH will achieve these goals in partnership with the Sofala provincial MOH, the Provincial Women's Committee for Social Action and Coordination (PWCSA), Health Alliance International (HAI), and Doctors with Africa (CUAMM), with whom we have collaborated closely in the development of this plan. The Care Group model will be the chief means of implementing interventions for nutrition and diarrhea, integrated through the household and community IMCI strategy throughout the ten districts of Sofala province. The nutrition intervention will receive 70% of the project effort, and control of diarrheal disease will receive the remaining 30% of effort. To accomplish this, 69 Promoters and 4,830 Leader Mothers working through 345 Care Groups will be trained and operating in Beira, Buzi, Caia, Chemba, Chibabava, Dondo, Gorongosa, Nhamatanda, Maringue and Marromeu districts. This program has been thoroughly discussed with both Dr. Abachaharus Saifodine, the Acting Team Leader of the Office of HPN and Titus Angi, Health, Population and Nutrition Specialist, both with the USAID mission in Mozambique. The main writer of this DIP document was: Lauren Erickson-Mamane, Child Survival and Nutrition Program Coordinator, Food for the Hungry, 236 Massachusetts Ave., NE Suite 305, Washington DC 20002, lauren.erickson@fh.org, phone (202)-547- 0560. Tom Davis, Director of Health Programs, tom.davis@fh.org, and Emma Hernandez, Child Survival Manager FH/Moz, ehernandez@fh.net were also actively involved in the writing of the DIP. The MOH and partner organizations were involved in the preparation of this document through their active participation in the start-up, KPC Analysis, and DIP workshops, and we appreciate the support that they are giving to this program

Project Location

Latitude: -12.90
Longitude: 39.71
Project Location Types: Peri-urban
Rural
Levels of Intervention: Home
Community
Province(s): Sofala
District(s): Seven districts in Sofala Province: Beira, Caia, Chemba, Dondo, Gorongosa, Nhamatanda, and Maringue districts
Sub-District(s): --

Operations Research Information

OR Project Title: Zinc OR and Care Group OR
Cost of OR Activities: $200,000
Research Partner(s): National Institute of Health (INS)
World Health Organization (OMS)
Mozambique Ministry of Health (MISAU)
OR Project Description: Zinc OR

Research Question: Feasibility and effectiveness of community-based delivery for Zinc tablets by CHWs (e.g. Leader Mothers and C-IMCI trained Leader Mothers -- Care Group Approach) for the management of diarrhea

Study Area: One rural and one semi - urban district (50% of villages of Caia district and in the town of Manga)

Deliverables: 1. Preliminary report on illness narratives and semi-structured interviews (Mbofana to send)

2. IEC materials (use at health facility and community levels) and media (4000 pamphlets and posters; TV spot) -- available from Daisy

3. Training curriculum and manual for diarrhea which includes Zn and can be adapted for APE program

4. Policy brief (Mbofana will share malaria policy brief with key findings) -- have a good system at NIH to develop these and will obtain input from Child Health Division

5. Report with key findings

Budget: $200,000

Care Group OR

The objective of the Care Group Operational Research was to identify the key components to the effective use of the Care Group Methodology. The OR included qualitative and quantitative survey methods to determine if the Care Group methodology was carried out as designed and identified methodological adaptations that occurred based on problems and difficulties that arose.

Partners

District level MOH offices (Collaborating Partner)	$0
CUAMM (Collaborating Partner)	$0
HAI (Collaborating Partner)	$0
Comunassas (Collaborating Partner)	$0

Strategies

Social and Behavioral Change Strategies: Community Mobilization
Group interventions
Interpersonal Communication
Health Services Access Strategies: Addressing social barriers (i.e. gender, socio-cultural, etc)
Implementation in a geographic area that the government has identified as poor and underserved
Health Systems Strengthening: Developing/Helping to develop job aids
Providing feedback on health worker performance
Referral-counterreferral system development for CHWs
Community role in supervision of CHWs
Community role in recruitment of CHWs
Strategies for Enabling Environment: Create/Update national guidelines/protocols
Advocacy for revisions to national guidelines/protocols
Stakeholder engagement and policy dialogue (local/state or national)
Advocacy for policy change or resource mobilization
Building capacity of communities/CHOs to advocate to leaders for health
Tools/Methodologies: HEIAVE Framework
Rapid Health Facility Assessment
Community-based Monitoring of Vital Events
LQAS
Lives Saved Calculator

Capacity Building

Local Partners: Local Non-Government Organization (NGO)
Traditional Healers
National Ministry of Health (MOH)
Dist. Health System
Other National Ministry
Government sanctioned CHWs
Non-government sanctioned CHWs

Interventions & Components

Immunizations	IMCI Integration	CHW Training HF Training
Nutrition (70%) - EBA - Complementary Feeding from 6 months - Health - Continuous BF up to 24 months - Maternal Nutrition	IMCI Integration	CHW Training HF Training
Vitamin A	IMCI Integration	CHW Training HF Training
Micronutrients		CHW Training HF Training
Pneumonia Case Management	IMCI Integration	CHW Training HF Training
Control of Diarrheal Diseases (30%) - Water/Sanitation - Hand Washing - ORS/Home Fluids - Feeding/Breastfeeding - Care Seeking - Case Management/Counselling - POU Treatment of water - Zinc	IMCI Integration	CHW Training HF Training
Malaria	IMCI Integration	CHW Training HF Training
Maternal & Newborn Care	IMCI Integration	CHW Training HF Training
Healthy Timing/Spacing of Pregnancy	IMCI Integration	CHW Training HF Training
Breastfeeding	IMCI Integration	CHW Training HF Training
HIV/AIDS		CHW Training HF Training
Family Planning	IMCI Integration	CHW Training HF Training
Tuberculosis	IMCI Integration	CHW Training HF Training

Operational Plan Indicators

Number of People Trained in Maternal/Newborn Health			
Gender	**Year**	**Target**	**Actual**
Female	2010	56486	
Female	2010		55546
Male	2010		300
Male	2010	0	
Female	2011	0	
Male	2011	0	
Female	2012	0	
Male	2012	0	
Number of People Trained in Child Health & Nutrition			
Gender	**Year**	**Target**	**Actual**
Female	2010	56546	
Female	2010		55546
Male	2010		300
Male	2010	0	
Female	2011	0	
Male	2011	0	
Female	2012	0	
Male	2012	0	
Number of People Trained in Malaria Treatment or Prevention			
Gender	**Year**	**Target**	**Actual**
Female	2010		51688
Female	2010	381	
Male	2010		300
Male	2010	0	
Female	2011	0	
Male	2011	0	
Female	2012	0	
Male	2012	0	

Locations & Sub-Areas

Phase I: Caia, Chemba, Maringue, and Manga	279,675
Phase II: Dondo, Gorongosa, and Nhamatanda	448,336
Total Population:	728,011

Target Beneficiaries

	Phase I: Caia, Chemba, Maringue, and Manga	**Phase II: Dondo, Gorongosa, and Nhamatanda**	**Total**
Children 0-59 months	64,514	83,629	148,143
Women 15-49 years	30,994	40,178	71,172
Beneficiaries Total	95,508	123,807	219,315

Rapid Catch Indicators: DIP Submission

Sample Type: LQAS

Underweight Children

Description -- Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)

Numerator: No. of children age 0-23 months whose weight (Rapid CATCH Question 7) is -2 SD from the median weight of the WHO/NCHS reference population for their age

Denominator: Number of children age 0-23 months in the survey who were weighed (response=1 for Rapid CATCH Question 6)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Mangu	146	557	26.2%	3.7
Phase II: Dondo, Gorongosa, and Nhamatanda	171	582	29.4%	3.7

Birth Spacing

Description -- Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child

Numerator: No. of children age 0-23 months whose date of birth is at least 24 months after the previous surviving sibling's date of birth

Denominator: Number of children age 0-23 months in the survey who have an older surviving sibling

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Mangu	54	91	59.3%	10.1
Phase II: Dondo, Gorongosa, and Nhamatanda	58	93	62.4%	9.8

Delivery Assistance

Description -- Percentage of children age 0-23 months whose births were attended by skilled health personnel

Numerator: No. of children age 0-23 months with responses =A ('doctor'), B ('nurse/midwife'), or C ('auxiliary midwife') for Rapid CATCH Question 10D

Denominator: Number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Mangu	103	199	51.8%	6.9
Phase II: Dondo, Gorongosa, and Nhamatanda	120	207	58.0%	6.7

Maternal TT

Description -- Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child

Numerator: Number of mothers of children age 0-23 months with responses=2 ('twice') or 3 ('more than two times') for Rapid CATCH Question 9

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Mangu	94	199	47.2%	6.9
Phase II: Dondo, Gorongosa, and Nhamatanda	110	207	53.1%	6.8

Exclusive Breastfeeding

Description -- Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours

Numerator: Number of infants age 0-5 months with only response=A ('breastmilk') for Rapid CATCH Question 13

Denominator: Number of infants age 0-5 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Mangu	9	52	17.3%	10.3
Phase II: Dondo, Gorongosa, and Nhamatanda	33	53	62.3%	13.1

Complementary Feeding

Description -- Percentage of infants age 6-9 months receiving breastmilk and complementary foods

Numerator: Number of infants age 6-9 months with responses= A ('breastmilk') and D ('mashed, pureed, solid, or semi-solid foods') for Rapid CATCH Question 13

Denominator: Number of infants age 6--9 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Mangu	24	30	80.0%	14.3
Phase II: Dondo, Gorongosa, and Nhamatanda	35	38	92.1%	8.6

Full Vaccination

Description -- Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday

Numerator: Number of children age 12-23 months who received Polio3 (OPV3), DPT3, and measles vaccines before the first birthday, according to the child's vaccination card (as documented in Rapid CATCH Question 15)

Denominator: Number of children age 12-23 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by interviewer' for Rapid CATCH Question 14)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Mangu	73	91	80.2%	8.2
Phase II: Dondo, Gorongosa, and Nhamatanda	93	104	89.4%	5.9

Measles

Description -- Percentage of children age 12-23 months who received a measles vaccine

Numerator: Number of children age 12-23 months with response=1 ('yes') for Rapid CATCH Question 16

Denominator: Number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Cain, Chemba, Maringue, and Manga	75	100	75.0%	8.5
Phase II: Dondo, Gorongosa, and Nhamatanda	70	101	69.3%	9.0

Bednets

Description -- Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)

Numerator: Number of children age 0-23 months with 'child' (response=A) mentioned among responses to Rapid CATCH Question 18 AND response=1 ('yes') for Rapid CATCH Question 19

Denominator: Number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Cain, Chemba, Maringue, and Manga	69	199	34.7%	6.6
Phase II: Dondo, Gorongosa, and Nhamatanda	33	211	15.6%	4.9

Danger Signs

Description -- Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment

Numerator: Number of mothers of children age 0-23 months who report at least two of the signs listed in B through H of Rapid CATCH Question 20

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Cain, Chemba, Maringue, and Manga	149	199	74.9%	6.0
Phase II: Dondo, Gorongosa, and Nhamatanda	172	211	81.5%	5.2

Sick Child

Description -- Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks

Numerator: Number of children age 0-23 months with response=3 ('more than usual') for Rapid CATCH Question 22 AND response=2 ('same amount') or 3 ('more than usual') for Rapid CATCH Question 23

Denominator: Number of children surveyed who were reportedly sick in the past two weeks (children with any responses A-H for Rapid CATCH Question 21)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Cain, Chemba, Maringue, and Manga	13	167	7.8%	4.1
Phase II: Dondo, Gorongosa, and Nhamatanda	15	211	7.1%	3.5

HIV/AIDS

Description -- Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection

Numerator: Number of mothers of children age 0-23 months who mention at least two of the responses that relate to safer sex or practices involving blood (letters B through I & O) for Rapid CATCH Question 25

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Cain, Chemba, Maringue, and Manga	69	199	34.7%	6.6
Phase II: Dondo, Gorongosa, and Nhamatanda	92	207	44.4%	6.8

Handwashing

Description -- Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated

Numerator: Number of mothers of children age 0-23 months who mention responses B through E for Rapid CATCH Question 26

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Cain, Chemba, Maringue, and Manga	2	199	1.0%	1.4
Phase II: Dondo, Gorongosa, and Nhamatanda	27	211	12.8%	4.5

Rapid Catch Indicators: Mid-term

Sample Type: LQAS

Underweight Children

Description -- Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)

Numerator: No. of children age 0-23 months whose weight (Rapid CATCH Question 7) is -2 SD from the median weight of the WHO/NCHS reference population for their age

Denominator: Number of children age 0-23 months in the survey who were weighed (response=1 for Rapid CATCH Question 6)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Mangu	27	151	17.9%	6.1
Phase II: Dondo, Gorongosa, and Nhamatanda	28	105	26.7%	8.5

Birth Spacing

Description -- Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child

Numerator: No. of children age 0-23 months whose date of birth is at least 24 months after the previous surviving sibling's date of birth

Denominator: Number of children age 0-23 months in the survey who have an older surviving sibling

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Mangu	0	0	0.0%	0.0
Phase II: Dondo, Gorongosa, and Nhamatanda	0	0	0.0%	0.0

Delivery Assistance

Description -- Percentage of children age 0-23 months whose births were attended by skilled health personnel

Numerator: No. of children age 0-23 months with responses =A ('doctor'), B ('nurse/midwife'), or C ('auxiliary midwife') for Rapid CATCH Question 10D

Denominator: Number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Mangu	0	0	0.0%	0.0
Phase II: Dondo, Gorongosa, and Nhamatanda	0	0	0.0%	0.0

Maternal TT

Description -- Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child

Numerator: Number of mothers of children age 0-23 months with response=2 ('twice') or 3 ('more than two times') for Rapid CATCH Question 9

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Mangu	0	0	0.0%	0.0
Phase II: Dondo, Gorongosa, and Nhamatanda	0	0	0.0%	0.0

Exclusive Breastfeeding

Description -- Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours

Numerator: Number of infants age 0-5 months with only response=A ('breastmilk') for Rapid CATCH Question 13

Denominator: Number of infants age 0-5 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Mangu	0	0	0.0%	0.0
Phase II: Dondo, Gorongosa, and Nhamatanda	0	0	0.0%	0.0

Complementary Feeding

Description -- Percentage of infants age 6-9 months receiving breastmilk and complementary foods

Numerator: Number of infants age 6-9 months with response= A ('breastmilk') and D ('mashed, pureed, solid, or semi-solid foods') for Rapid CATCH Question 13

Denominator: Number of infants age 6--9 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Mangu	0	0	0.0%	0.0
Phase II: Dondo, Gorongosa, and Nhamatanda	0	0	0.0%	0.0

Full Vaccination

Description -- Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday

Numerator: Number of children age 12-23 months who received Polio3 (OPV3), DPT3, and measles vaccines before the first birthday, according to the child's vaccination card (as documented in Rapid CATCH Question 15)

Denominator: Number of children age 12-23 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by interviewer' for Rapid CATCH Question 14)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Mangu	0	0	0.0%	0.0
Phase II: Dondo, Gorongosa, and Nhamatanda	0	0	0.0%	0.0

Measles

Description -- Percentage of children age 12-23 months who received a measles vaccine

Numerator: Number of children age 12-23 months with response=1 ('yes') for Rapid CATCH Question 16

Denominator: Number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Manga	0	0	0.0%	0.0
Phase II: Dondo, Gorongosa, and Nhamatanda	0	0	0.0%	0.0

Bednets

Description -- Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)

Numerator: Number of children age 0-23 months with 'child' (response=A) mentioned among responses to Rapid CATCH Question 18 AND response=1 ('yes') for Rapid CATCH Question 19

Denominator: Number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Manga	0	0	0.0%	0.0
Phase II: Dondo, Gorongosa, and Nhamatanda	0	0	0.0%	0.0

Danger Signs

Description -- Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment

Numerator: Number of mothers of children age 0-23 months who report at least two of the signs listed in B through H of Rapid CATCH Question 20

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Manga	0	0	0.0%	0.0
Phase II: Dondo, Gorongosa, and Nhamatanda	0	0	0.0%	0.0

Sick Child

Description -- Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks

Numerator: Number of children age 0-23 months with response=3 ('more than usual') for Rapid CATCH Question 22 AND response=2 ('same amount') or 3 ('more than usual') for Rapid CATCH Question 23

Denominator: Number of children surveyed who were reportedly sick in the past two weeks (children with any responses A-H for Rapid CATCH Question 21)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Manga	0	0	0.0%	0.0
Phase II: Dondo, Gorongosa, and Nhamatanda	0	0	0.0%	0.0

HIV/AIDS

Description -- Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection

Numerator: Number of mothers of children age 0-23 months who mention at least two of the responses that relate to safer sex or practices involving blood (letters B through I & O) for Rapid CATCH Question 25

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Manga	0	0	0.0%	0.0
Phase II: Dondo, Gorongosa, and Nhamatanda	0	0	0.0%	0.0

Handwashing

Description -- Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated

Numerator: Number of mothers of children age 0-23 months who mention responses B through E for Rapid CATCH Question 26

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Manga	0	0	0.0%	0.0
Phase II: Dondo, Gorongosa, and Nhamatanda	0	0	0.0%	0.0

Rapid Catch Indicators: Final Evaluation

Sample Type: LQAS

Underweight Children

Description -- Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)

Numerator: No. of children age 0-23 months whose weight (Rapid CATCH Question 7) is -2 SD from the median weight of the WHO/NCHS reference population for their age

Denominator: Number of children age 0-23 months in the survey who were weighed (response=1 for Rapid CATCH Question 6)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Cain, Chemba, Maringue, and Manga	117	571	20.5%	3.3
Phase II: Dondo, Gorongosa, and Nhamatanda	113	582	19.4%	3.2

Birth Spacing

Description -- Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child

Numerator: No. of children age 0-23 months whose date of birth is at least 24 months after the previous surviving sibling's date of birth

Denominator: Number of children age 0-23 months in the survey who have an older surviving sibling

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Cain, Chemba, Maringue, and Manga	75	105	71.4%	8.6
Phase II: Dondo, Gorongosa, and Nhamatanda	92	113	81.4%	7.2

Delivery Assistance

Description -- Percentage of children age 0-23 months whose births were attended by skilled health personnel

Numerator: No. of children age 0-23 months with responses =A ('doctor'), B ('nurse/midwife'), or C ('auxiliary midwife') for Rapid CATCH Question 10D

Denominator: Number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Cain, Chemba, Maringue, and Manga	154	196	78.6%	5.7
Phase II: Dondo, Gorongosa, and Nhamatanda	152	198	76.8%	5.9

Maternal TT

Description -- Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child

Numerator: Number of mothers of children age 0-23 months with responses=2 ('2+for') or 3 ('more than two times') for Rapid CATCH Question 9

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Cain, Chemba, Maringue, and Manga	139	196	70.9%	6.4
Phase II: Dondo, Gorongosa, and Nhamatanda	127	198	64.1%	6.7

Exclusive Breastfeeding

Description -- Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours

Numerator: Number of infants age 0-5 months with only response=A ('breastmilk') for Rapid CATCH Question 13

Denominator: Number of infants age 0-5 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Cain, Chemba, Maringue, and Manga	36	47	76.6%	12.1
Phase II: Dondo, Gorongosa, and Nhamatanda	39	45	86.7%	9.9

Complementary Feeding

Description -- Percentage of infants age 6-9 months receiving breastmilk and complementary foods

Numerator: Number of infants age 6-9 months with responses= A ('breastmilk') and D ('mashed, pureed, solid, or semi-solid foods') for Rapid CATCH Question 13

Denominator: Number of infants age 6--9 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Cain, Chemba, Maringue, and Manga	33	34	97.1%	5.7
Phase II: Dondo, Gorongosa, and Nhamatanda	28	28	100.0%	0.0

Full Vaccination

Description -- Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday

Numerator: Number of children age 12-23 months who received Polio3 (OPV3), DPT3, and measles vaccines before the first birthday, according to the child's vaccination card (as documented in Rapid CATCH Question 15)

Denominator: Number of children age 12-23 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by interviewer' for Rapid CATCH Question 14)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Cain, Chemba, Maringue, and Manga	72	101	71.3%	8.8
Phase II: Dondo, Gorongosa, and Nhamatanda	67	99	67.7%	9.2

Measles

Description -- Percentage of children age 12-23 months who received a measles vaccine

Numerator: Number of children age 12-23 months with response=1 ('yes') for Rapid CATCH Question 16

Denominator: Number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Manga	76	80	95.0%	4.8
Phase II: Dondo, Gorongosa, and Nhamatanda	80	98	81.6%	7.7

Bednets

Description -- Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)

Numerator: Number of children age 0-23 months with 'child' (response=A) mentioned among responses to Rapid CATCH Question 18 AND response=1 ('yes') for Rapid CATCH Question 19

Denominator: Number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Manga	158	198	79.8%	5.6
Phase II: Dondo, Gorongosa, and Nhamatanda	174	199	87.4%	4.6

Danger Signs

Description -- Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment

Numerator: Number of mothers of children age 0-23 months who report at least two of the signs listed in B through H of Rapid CATCH Question 20

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Manga	193	198	97.5%	2.2
Phase II: Dondo, Gorongosa, and Nhamatanda	194	199	97.5%	2.2

Sick Child

Description -- Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks

Numerator: Number of children age 0-23 months with response=3 ('more than usual') for Rapid CATCH Question 22 AND response=2 ('same amount') or 3 ('more than usual') for Rapid CATCH Question 23

Denominator: Number of children surveyed who were reportedly sick in the past two weeks (children with any responses A-H for Rapid CATCH Question 21)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Manga	25	45	55.6%	14.5
Phase II: Dondo, Gorongosa, and Nhamatanda	24	44	54.5%	14.7

HIVAIDS

Description -- Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection

Numerator: Number of mothers of children age 0-23 months who mention at least two of the responses that relate to safer sex or practices involving blood (letters B through I & O) for Rapid CATCH Question 25

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Manga	148	196	75.5%	6.0
Phase II: Dondo, Gorongosa, and Nhamatanda	143	198	72.2%	6.2

Handwashing

Description -- Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated

Numerator: Number of mothers of children age 0-23 months who mention responses B through E for Rapid CATCH Question 26

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Phase I: Caia, Chemba, Maringue, and Manga	100	198	50.5%	7.0
Phase II: Dondo, Gorongosa, and Nhamatanda	86	199	43.2%	6.9

Rapid Catch Indicator Comments

Annex 20. Grantee Plans to Address Final Evaluation Findings

Further studies: An independent assessment of the findings of this evaluation, including a retrospective assessment of under-five mortality changes over the past 15 years, is indicated.

Policy: Make policymakers in Mozambique as well as in other countries in Africa and beyond aware of the effectiveness of Care Groups in reducing child mortality and malnutrition.

Funding: Seek funding to maintain and expand this project, to include community-based HIV/AIDS and tuberculosis control activities, and to further disseminate the achievements that have been documented here.

Preparation of Flipcharts: Additional effort and time should be taken to ensure images are easily understood by participants. More time be taken during the CG meetings to ensure the LM remembers the complete key message. When officials supervise Promoters and LMs, their supervision checklist instructs them to check key message association with images, it appears more care needs to be taken in the supervision process to assure the correct and complete communication of messages.

Annex 21. Photographs Taken During the Evaluation

Volunteer Leader Mothers (Care Group Members)

(singing, dancing and praying are core activities!)

Project Staff and Offices

Joana Domingos, Promoter, with Her Bicycle Provided by the Project

Amelia Azevedo, District Supervisor, in Her Leather Protective Gear and with Her Motorcycle Provided by the Project

Project Leadership with Supervisor and Promoters in Caia District

Project District Office in Caia

The Project Leadership:
From left to right, Tom Davis, HQ Backstop and Senior Director of Health Programs; Luciano Menete, Program Coordinator; Emma Hernandez, Program Manager (above); Joaqui Bande, Driver (in front); Jose Carlo Manuel, Zinc Coordinator; and Orlando Zuro, Administrator

Food for the Hungry Project Office in Beira

Project Activities

Leader Mothers and Beneficiary Mothers Preparing a Nutritious Meal for Their Children (containing rice flour, cassava, peanuts, and green leafy vegetables)

The "Tippy Tap" (Introduced by the Project) in Use during a Care Group Meeting

Typical Household Latrine (Promoted by the Project)

Inside the Latrine, with Its Removable Cover

Administration of Vitamin A and De-Worming Medication

Village Life

Ministry of Health Facility-Based Services

Chemba Health Center

Triage/Intake Desk at Health Center

Activities of the Final Evaluation Team

Henry Perry interviewing Mr. Luciana Cresimo (Medical Technician), Director of the Chemba Health District

Focus Group Discussion with Beneficiary Mothers, Tom Davis and Promoter (Rocha Antonio)

Focus Group Discussion with Beneficiary Mothers, Henry Perry (Lead Evaluator), Barrosa Linda (Supervisor) and Emma Hernandez (Project Manager)

Focus Group Discussion with Community Leaders and Tom Davis (FH Senior Director of Health Programs) and Cecelia Lopes (M&E Coordinator)

The Project Manager Emma Hernandez (right), and the Headquarters Technical Support Staff and Senior Director of Health Programs Tom Davis (left) enjoying a nutritious meal of corn flour, malambe (fruit from a baobab tree), oil, and sugar

Drama of a Newborn Home Visit Performed for the Evaluation Team by a beneficiary mother and a Leader Mother

The "Boss" Trying Out Another "Tippy Tap"

Expressions of Deep Gratitude Given by a Care Group to the Project Leadership (chickens, corn, pumpkin, cassava, sweet potato, peanuts, beans, and even a goat that is not shown!)

More Expressions of Deep Gratitude from Another Care Group

Cecelia Lopes, Project Monitoring and Evaluation Coordinator, Giving a Presentation of the Project Findings to the MOH and NGO Colleagues in Beira (21 July 2010)

Presentation of Findings to Representatives of Governmental Organizations And NGOs (27 July 2010)

Mothers and Children

Men

ANNEX 22: Final KPC Report

Achieving Equity, Coverage, and Impact through a Care Group Network

Project Location: Mozambique, Sofala Province

In the districts of: Caia, Chemba, Maringue, Marromeu, Beira, Dondo, Gorongosa, & Nhamatanda

October 1, 2005 – September 30, 2010

Cooperative Agreement No. GHS-A-00-05-0014-00

Report Submitted: October 24 2008

End of Project Evaluation

May 31 – June 4 2010

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ACRONYMS

ACS	Community health agent, a community level health worker within the MOH system. These have been paid during some periods.
BCC	Behavior change communication
CDC	Community Development Committees
CG	Care Group
C-IMCI	Community-based integrated management of childhood illness.
CDC	Community development committee
CSP	Child Survival Project
DIP	Detailed implementation plan
DPS	Provincial Health Department
EBF	Exclusive breastfeeding
EOP	End of project
FGD	Focus group discussions
FH	Food for the Hungry
GM	Growth monitoring (not genetically modified)
HAI	Health Alliance International
HH-IMCI	Home health IMCI—similar to C-IMCI
HMIS	Health management information system
IMCI	Integrated management of childhood illness.
ITN	Insecticide treated mosquito net
KPC	Knowledge, practice and coverage survey
LM	Leader Mother. C-IMCI LM Leader Mother trained in community-based IMCI. One for every twelve mothers. 14 per Care Group
LOE	Level of effort.
LQAS	Lot quality assurance sampling

M&E, M and E	Monitoring and evaluation
MOU	Memorandum of understanding
MUAC	Mid upper arm circumference (a rapid nutrition screening technique)
MOH	Ministry of Health
MOU	Memorandum of understanding
MPH	Masters in Public Health
MTE	Mid-term evaluation
OR	Operations research
ORS	Oral rehydration salts
ORT	Oral rehydration therapy
POU	Point of use
PSI	Population Services International, an international NGO specializing in social marketing
QIVC	Quality improvement and verification checklist
USAID	United States Agency for International Development

A. Methodology

Questionnaire

The same questionnaire used in the 2007 Phase I Districts CS baseline and 2009 Phase II baseline was used. This questionnaire was developed in the following manner: Generic KPC 2000+ and RapidCATCH questionnaires developed by CSTS were used as a starting point in the KPC questionnaire development for this survey. The project proposal and indicators were used to modify this basic format. The modules that were included in the original questionnaire design were:

- The informed consent and cover page;
- child spacing table (from the RapidCATCH);
- questions on water and sanitation;
- questions on maternal and newborn care (from RapidCATCH);
- questions on breastfeeding and infant/child nutrition;
- questions on diarrhea management including ORS preparation;
- questions on immunizations;
- questions on childhood illness;
- other RapidCATCH questions on use of mosquito nets and knowledge of AIDS prevention;
- questions on growth monitoring; and
- a section on anthropometry.

A 15-page draft questionnaire was sent to the project staff on 2/10/2006, 10 days prior to beginning of the KPC field training (which began 20 February), for their review, edits, and pretesting. Additional documents were sent to the staff prior to the survey including KPC teaching modules on logistics, choosing and training interviewers and supervisors, sample size selection, and other topics.

Changes to the KPC questionnaire were suggested by field staff members and were incorporated in the final questionnaire. The questionnaire was then divided into a 0-11m and a 12-23m questionnaire, and the questionnaire was translated into Portuguese by FH staff in Mozambique. The questionnaire was translated with help from HAI partner staff and FH staff who spoke both English and Portuguese. The translated questionnaire was reviewed by two people who were not involved in the translation (but had the English copy) and changes were made. Skips were also reviewed by project staff and some corrections were made. Following the pretest, several modifications were made including:

- Coding categories for questions about foods (e.g., adding “maheu” a sugar solution beverage) and where people sought advice or treatment for sick children were adapted to the local situation;
- Fixing several skips in the questionnaire which were numbered incorrectly;
- Inclusion in the survey the mothers of a *randomly-selected* child 0-23 months of age in each household rather than biasing the sample towards the *youngest* child in each household.

Changes in the respondent selection instructions, consent form, and other parts of the questionnaire were made to reflect these changes.

The questionnaire was pretested on 21-22 February 2006. The questionnaire was pretested during the last day of interviewer training. Interviewers and Supervisors went to a community that was not selected for interviews, and each interviewer interviewed several mothers. Difficulties in responding to questions were discussed with mothers and needed modifications were noted.

The final questionnaire was in Portuguese, but interviewers asked the questions to the respondent based on the language in which the respondent was most comfortable (usually Sena). It was decided not to translate the written questionnaire into Sena or other languages because of the difficulty in finding someone to translate from English to Sena, and the time required to do two translations (English to Portuguese and Portuguese to Sena) properly.

Sampling Frame and Survey Details

Given that FH was interested in having management data for each supervision area (district) LQAS was the sampling methodology used. In order to get a reasonable denominator for questions asked of a sub-sample of respondents (e.g., mothers of children with diarrhea, mothers of children < 6m), we used parallel sampling: one questionnaire for children 0-11m of age and a separate one for children 12-23m of age.

In LQAS, a minimum of 5 SA's with lots of 19 each is needed to get the 96 surveys necessary to calculate average coverage across a program area (with 10% precision). This was rounded up to 100 and 100 interviews were conducted with each age group in both program areas, for a total of 400 respondents. Interviews per supervision area (or district) were weighted based on the population that would be reached by the CS program in each district. For example in Dondo, 55 of 175 CG were formed, this accounted for 31% of the Phase II program population, so 175 X 31% = 31 interviews to be done in Dondo. Thirty-two is higher than the minimum lot number for LQAS (19).

PHASE	District	CG	% of population in District	Planned Interviews per District	Actual Interviews per District	Difference
Phase I	Caia	25	19%	38	38	0
	Chemba	25	19%	38	38	0
	Maringue	35	26%	52	52	0
	Manga	50	37%	74	71	-3
	TOTAL Phase I	**135**		**202**	**199**	

Phase II	Dondo,	55	31%	62	61	-1
	Gorongosa,	60	34%	68	65	-3
	Nhamatanda	60	34%	68	73	5
	TOTAL Phase II	**175**		**198**	**199**	
PROJECT TOTAL		**310**		**400**	**398**	

A total of 398 mothers were interviewed and 1,200 children were weighed.

Anthropometry							
PHASE	**District**	0-11m index cases	0-11m parallel sample	12-23m index case	12-23m parallel sample	Total children	Total children after data cleaning
Phase I	Caia	19	38	19	38	114	
	Chemba	19	38	19	38	114	
	Maringue	26	52	26	52	156	
	Manga	36	71	36	71	213	
	TOTAL Phase I	**199**	**398**	**199**	**398**	**597**	**571**
Phase II	Dondo	31	61	31	61	183	
	Gorongosa	33	65	33	65	195	
	Nhamatanda	37	73	37	73	219	
	TOTAL Phase II	**199**	**398**	**199**	**398**	**597**	**582**
PROJECT TOTAL		**398**	**796**	**398**	**796**	**1194**	**1153**

The sample was then selected by:

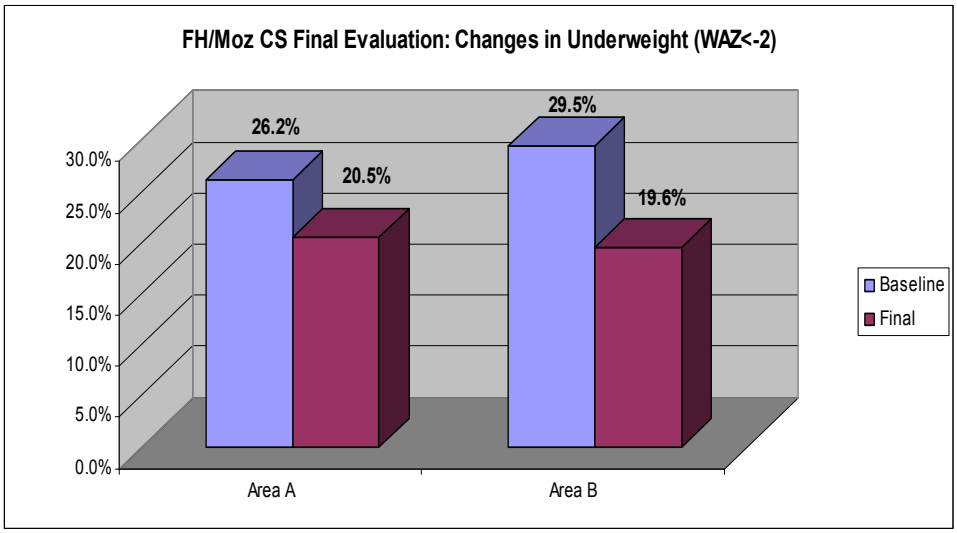
1. Listing all the care groups in each district
2. Dividing the total number of care groups in a district by the number of interviews programmed to be done in each district in order to obtain the sampling interval.
3. A random number was selected between 1 and the sampling interval. That was the first Care Group selected. The sampling frame was added to the random number to select the 2nd Care Group for interviews, the sampling frame was added to the previous number until all the Care Groups where interviews should occur was identified.

4. In each selected Care Group, a random number was used to determine which mother leader and her beneficiaries to interview. Then a list of the selected mother leader and all her beneficiaries was produced and random number was used to determine which mother to interview.

Computerization and analysis of data:

Data entry was done using Epi Info statistical software version 6.04d and Pocket PC Creations 5. Data analysis was done using EpiInfo 6.04d. Anthropometric data was analyzed using EpiNut 6.04d. Anthropometric data was cleaned in the following manner: The age of the index child was calculated. Then the age difference between the stated age and calculated age (from DOB) was determined. If the difference was more or less than 2 months, we removed the respondent from the anthropometry dataset. For the other children weighed, we calculated ages, and if any ages were negative, we removed those from the dataset as well. Flagged records were excluded from the analysis.

B. Results Tables



RapidCATCH Indicators for Area A

#	Project Indicators	Baseline				Endline			
		Numer-ator	Denom-inator	Percent-age	Confidence interval	Numer-ator	Denom-inator	Percent-age	Confidence interval
1	% of children 0-23m who are underweight (WAZ<-2.0)	146	557	26.2%	22.6-30.1%	117	571	20.5%	17.2-23.8%
2	Percentage of children age 0-23m who were born at least 24 months after the previous surviving child	54	91	59%	48.5-69.5%	75	105	71.4%	61.8-79.8%
3	Percentage of children age 0-23m whose births were attended by skilled health personnel	103	199	52%	44.6-58.9%	154	196	78.6%*	72.2-84.1%
4	Percentage of mothers with children age 0-23m who received at least two TT injections before the birth of their youngest child	94	199	47%	40.0-54.0%	139	196	70.9%*	64.0-77.2%
5	Percentage of infants aged 0-5m who were fed breast milk only in the last 24 hours	9	52	17%	8.2-30.3%	36	47	76.6%*	62.0-87.7%
6	Percentage of children age 6-9m who received breast milk and complementary foods during the last 24 hours	24	30	80%	61.0-92.0%	33	34	97.1%	84.7-99.9%
7	Percentage of children age 12-23m who are fully vaccinated (against the 5 vaccine-preventable diseases) before the first birthday	73	91	80%	71.0-88.0%	72	101	71.3%	61.4-79.9%
8	Percentage of children age 12-23m who received a measles vaccine	75	100	75%	65.0-83.0%	76	80	95%*	90.2-99.8%
9	Percentage of children age 0-23m who slept under an insecticide-treated net (in malaria risk areas) the previous night	69	199	35%	28.0-42.0%	158	198	79.8%*	73.5-85.2%
10	Percentage of mothers with children age 0-23m who cite at least two known ways of reducing the risk of HIV infection	69	199	35%	28.0-42.0%	148	196	75.5%*	69.5-81.%
11	Percentage of mothers with children age 0-23m who report that they wash their hands with soap/ash before [4 times]	2	199	1%	0.1-34%	100	198	50.5%*	43.3-57.7%
12	Percentage of mothers of children age 0-23m who know at least two signs of childhood illness that indicate the need for treatment	149	199	75%	68.3-80.7%	193	198	97.5%*	94.2-99.2%
13	Percentage of sick children age 0-23m who received increased fluids and continued feeding during an illness in the past two weeks	13	167	8%	4.0-13.0%	25	45	55.6%*	40.0-70.4%

*Statistical significance <0.05

RapidCATCH Indicators for Area B

#	Project Indicators	Baseline				Endline			
		Numer-ator	Denom-inator	Percent-age	Confidence interval	Numer-ator	Denom-inator	Percent-age	Confidence interval
1	Percentage of children 0-23m who are underweight (WAZ<-2.0)	171	582	29.4%	26.4-34.5%	113	582	19.4%*	16.2-22.6%
2	Percentage of children age 0-23m who were born at least 24 months after the previous surviving child	58	93	62%	51.7-72.2%	92	113	81.4%*	73.0-88.1%
3	Percentage of children age 0–23m whose births were attended by skilled health personnel	120	207	58%	50.9-64.8%	152	198	76.8%*	70.3-82.5%
4	Percentage of mothers with children age 0–23m who received at least two TT injections before the birth of their youngest child	110	207	53%	46.1-60.1%	127	198	64.1%	57.0-70.8%
5	Percentage of infants aged 0-5m who were fed breast milk only in the last 24 hours	33	53	62%	47.9-75.2%	39	45	86.7%	73.2-94.9%
6	Percentage of children age 6-9m who received breast milk and complementary foods during the last 24 hours	35	38	92%	78.6-98.3%	28	28	100%	87.7- 100.0%
7	Percentage of children age 12-23m who are fully vaccinated (against the 5 vaccine-preventable diseases) before the first birthday[37]	93	104	89%	81.9-94.6%	67	99	67.7%*	57.5-76.7%
8	Percentage of children age 12-23m who received a measles vaccine	70	101	69%	59.3-78.1%	80	98	91.3%*	85.1-97.4%
9	Percentage of children age 0-23m who slept under an insecticide-treated net (in malaria risk areas) the previous night	33	211	16%	11-21.3%	174	199	87.4%*	82.0-91.7%
10	Percentage of mothers with children age 0-23m who cite at least two known ways of reducing the risk of HIV infection	92	207	44%	37.6-51.5%	143	198	72.2%*	66.0-78.5%
11	Percentage of mothers with children age 0–23 months who report that they wash their hands with soap/ash before [4 times]	27	211	13%	8.6-18.1%	86	199	43.2%*	36.2%-50.4%
12	Percentage of mothers of children age 0–23m who know at least two signs of childhood illness that indicate the need for treatment	172	211	82%	75.6-86.5%	194	199	97.5%*	94.2-99.2%
13	Percentage of sick children age 0-23m who received increased fluids and continued feeding during an illness in	15	211	7%	4-11.5%	24	44	54.5%*	38.8-69.6%

[37] At baseline, calculated on each of five vaccines. At final, calculated on DTP3 + measles as proxies. *Statistical significance <0.05

FH/Mozambique Child Survival Project (2005-2010), Other Indicators

		PHASE I			PHASE II		
#	*Other Indicators*	*Phase I Baseline Perc.*	*Phase I Final Perc.*	*Stat. Sig?*	*Phase II Baseline Perc.*	*Phase II Final Perc.*	Stat. Sig.?
1	**Purification of drinking water, any good method**	**41.1%**	**85.4%**	**Y**	12.3%	88.2%	**Y**
2	**Purification by boiling**	**5.2%**	**43.7%**	**Y**	**2.8%**	55.6%	**Y**
3	**Purification by chlorination**	**30.9%**	**59.6%**	**Y**	**11.3%**	63.4%	**Y**
4	**Purification by Certeza**	**8.2%**	**36.4%**	**Y**	**0.9%**	30.7%	**Y**
5	**Special place for HW (mother's rep.)**	**41.2%**	**83.3%**	**Y**	**52.6%**	81.4%	**Y**
6	**Soap/ash in HH (mother's rep.)**	**14.3%**	**96.3%**	**Y**	**3.3%**	75.4%	**Y**
7	**Basin in HH (mother's rep.)**	**37.9%**	**98.1%**	**Y**	**97.3%**	80.9%	**N**
8	**HWWS, before eating**	**41.7%**	**90.4%**	**Y**	**62.3%**	87.9%	**Y**
9	**HWWS, before feeding children**	**26.6%**	**77.3%**	**Y**	**54.2%**	73.9%	**Y**
10	**HWWS, after defecation**	**64.8%**	**93.4%**	**Y**	**70.3%**	88.4%	**Y**
11	**HWWS, after caring for child who def.**	**23.6%**	**70.2%**	**Y**	**23.1%**	62.8%	**Y**
12	**Mother received visit from LM in first week after birth**	**0.0%**	**96.9%**	**Y**	**0.0%**	100.0%	**Y**
13	**Helped with delivery: Doctor**	**0.0%**	**1.5%**	**N**	**0.5%**	0.5%	**N**
14	**Helped with delivery: Nurse / Midwife**	**54.8%**	**73.2%**	**Y**	**56.6%**	75.9%	**Y**
15	**Helped with delivery: Midwife Assistant**	**8.0%**	**25.3%**	**Y**	**13.2%**	18.1%	**Y**
16	**Helped with delivery: TBA**	**18.6%**	**3.0%**	**N**	**7.5%**	3.0%	**N**
17	**Helped with delivery: CHW**	**2.7%**	**9.6%**	**Y**	**1.9%**	6.5%	**Y**
18	**Helped with delivery: Family Member**	**20.7%**	**17.2%**	**N**	**29.2%**	18.6%	**N**
19	**Helped with delivery: Leader Mother**	**0.0%**	**7.1%**	**Y**	**0.0%**	3.5%	**Y**
20	**Mothers who took 3m+ of iron supp.**	**32.0%**	**79.4%**	**Y**	**35.2%**	70.4%	**Y**
21	**Average months of antenatal care**	**-**	**-**		**-**	4.4 mon	
22	**Mothers who had 4+ antenatal care visits**	**-**	**81.6%**	**Y**	**-**	66.0%	
23	**Immediate BF, first hour**	**43.2%**	**85.7%**	**Y**	**47.3%**	92.9%	**Y**
24	**BF w/in 8 hrs**	**100.0%**	**100.0%**	**N**	**100.0%**	98.0%	**N**

FH/Mozambique Child Survival Project (2005-2010), Other Indicators

		PHASE I			PHASE II		
#	Other Indicators	Phase I Baseline Perc.	Phase I Final Perc.	Stat. Sig?	Phase II Baseline Perc.	Phase II Final Perc.	Stat. Sig.?
25	Gave prelacteal foods (first 3d)	12.4%	3.0%	N	2.9%	5.1%	N
26	Currently BF	92.3%	88.3%	N	99.0%	91.2%	N
27	Cont. BF, 20-23m		53.6%	Y		56.0%	
28	Bottle feeding	11.5%	14.3%	N	6.7%	8.7%	N
29	Diarrhea last 2 weeks	40.2%	22.7%	Y	39.2%	22.1%	Y
30	Diarrhea, gave pill/syrup	28.8%	62.2%	Y	24.4%	53.5%	Y
31	Diarrhea, gave ORS packets	60.0%	93.3%	Y	56.1%	88.4%	Y
32	Diarrhea, breastfed more often	15.0%	62.8%	Y	29.8%	65.0%	Y
33	Diarrhea, gave more to drink (> 5m)	25.0%	67.4%	Y	30.7%	72.5%	Y
34	Gave same/more food (age>5m)	14.1%	83.3%	Y	11.7%	57.5%	Y
35	Gave more food week after diarrhea (age>5m)	26.8%	68.2%	Y	30.7%	85.0%	Y
36	Child slept under ITN	34.7%	79.8%	Y	43.1%	89.4%	Y
37	Knowl. of HIV prev: abstain	14.0%	22.7%	N	7.1%	16.2%	Y
38	Knowl. of HIV prev: condoms	30.6%	77.8%	Y	38.9%	73.1%	Y
39	Knowl. of HIV prev: Fidelity/limit partner to 1	37.3%	71.2%	Y	53.1%	79.2%	Y
40	Knowl. of HIV preven: Avoid sex w/prostitutes	5.2%	26.3%	Y	6.6%	26.4%	Y
41	Poor knowl. of HIV: Avoid HIV by avoiding mosq bites, kissing, or seeking protection from a trad. Healer	2.5%	3.0%	N	3.3%	1.0%	N
42	Has growth card	88.4%	87.4%	N	83.9%	80.4%	N
43	Weighed w/in first 2m (age<12m)	78.4%	96.6%	Y	81.3%	91.7%	Y
44	Weighed in last 4m	69.7%	87.7%	Y	66.1%	83.0%	Y
45	Mother received postpartum vitamin A	-	70.4%	Y	-	70.4%	
46	Mother knows 2+ p/p danger signs	-	79.3%	Y	-	83.9%	
47	Mother knows all three p/p danger signs	-	47.0%	Y	-	45.2%	

FH/Mozambique Child Survival Project (2005-2010), Other Indicators

		PHASE I			PHASE II		
#	Other Indicators	Phase I Baseline Perc.	Phase I Final Perc.	Stat. Sig?	Phase II Baseline Perc.	Phase II Final Perc.	Stat. Sig.?
48	Mother BF both breasts	-	91.7%	Y	-	95.9%	
49	Completely empties both breasts	-	93.8%	Y	-	91.9%	
50	Proper knowledge food conservation	-	99.0%	Y	-	98.5%	
51	LM visited mother last 2 weeks	0.0%	91.9%	Y	-	95.4%	
52	Knows when to start BF	-	90.8%		-	89.4%	
53	Believes okay to BF when pregnant	-	33.3%		-	43.9%	
54	Believes women are equally valuable as men	-	42.1%		-	47.7%	
55	Believes either women are equally valuable as men, or women are better	-	54.4%		-	66.0%	
56	Knows how to BF when HIV+	-	76.2%		-	72.7%	
57	Knowl. of anemia prev: Eat iron rich foods	-	90.4%		-	91.9%	
58	Knowl. of anemia prev: Take iron supplements	-	84.3%		-	76.3%	
59	Knowl. of anemia prev: Slept under ITN	-	30.8%		-	23.7%	
60	Child had fever last 2 weeks	-	34.6%		-	31.7%	
61	Fever, sought care	-	95.1%		-	91.2%	
62	Fever, sought care for fever from proper source	-	86.4%		-	98.1%	
63	Fever, sought care from traditional healer	-	0.0%		-	0.0%	
64	Fever, sought care from IMCI-trained LM (+ HF staff)	-	42.1%		-	28.8%	
65	Fever, sought care from non-IMCI trained LM	-	5.3%		-	11.5%	
66	Fever, sought care from medical person	-	86.4%		-	98.1%	
67	Fever, sought care from medical person + IMCI-trained LM	-	83.3%		-	98.1%	
68	Believes malaria caused by mosquito bite	-	96.4%		-	95.5%	Y
69	DTP: 3 doses (of those with cards, 12-23m)	64.8%	93.0%	Y	63.3%	85.2%	Y
70	DTP: 2+ doses	75.8%	97.7%	Y	72.2%	92.6%	Y

FH/Mozambique Child Survival Project (2005-2010), Other Indicators

		PHASE I			PHASE II		
#	*Other Indicators*	*Phase I Baseline Perc.*	*Phase I Final Perc.*	*Stat. Sig?*	*Phase II Baseline Perc.*	*Phase II Final Perc.*	Stat. Sig.?
71	**DTP 1+ dose**	**96.7%**	**98.8%**	**N**	**83.5%**	100.0%	**Y**
72	**DTP: 3 doses (of all children 12-23m)**	**58.4%**	**79.2%**	**Y**	**48.1%**	69.7%	**Y**
73	**Mother frequently sees Doctor**	**-**	**4.1%**		**-**	2.1%	
74	**Mother frequently sees Nurse / Trained Midwife**	**-**	**54.6%**		**-**	49.7%	
75	**Mother frequently sees Leader Mother / Health Ed. / CHW**	**-**	**82.1%**		**-**	75.4%	
76	**Mother frequently sees TBA**	**-**	**1.1%**		**-**	1.5%	
77	**Mother frequently sees Traditional Healer**	**-**	**3.2%**		**-**	1.5%	
78	**(Mother never sees Traditional Healer)**	**-**	**90.0%**		**-**	89.8%	
79	**Gets info on health/nut: Doctor**	**-**	**6.6%**		**-**	3.0%	
80	**Gets info on health/nut: Nurse / Trained Midwife**	**-**	**68.7%**		**-**	65.8%	
81	**Gets info on health/nut: LM / Health Ed. / CHW**	**-**	**92.9%**		**-**	95.5%	
82	**Gets info on health/nut: TBA**	**-**	**2.5%**		**-**	2.5%	
83	**Gets info on health/nut: Husband / Partner**	**-**	**41.4%**		**-**	34.7%	
84	**Gets info on health/nut: Mother / Mother-in-law**	**-**	**37.4%**		**-**	35.2%	
85	**Gets info on health/nut: Sister**	**-**	**6.6%**		**-**	3.5%	
86	**Gets info on health/nut: Grandparents**	**-**	**12.6%**		**-**	10.1%	
87	**Gets info on health/nut: Aunt**	**-**	**6.1%**		**-**	1.5%	
88	**Gets info on health/nut: Friend / Neighbor**	**-**	**28.8%**		**-**	19.6%	
89	**Gets info on health/nut: Traditional Healer**	**-**	**1.0%**		**-**	2.0%	
90	**Gets info on health/nut: Elders**	**-**	**12.1%**		**-**	13.1%	
91	**Gets info on health/nut: Other**	**-**	**3.5%**		**-**	3.0%	
92	**Received health msg last month from Radio**	**-**	**60.6%**		**-**	47.5%	
93	**Received health msg last month from Newspaper**	**-**	**0.5%**		**-**	0.5%	

FH/Mozambique Child Survival Project (2005-2010), Other Indicators

		PHASE I			PHASE II		
#	*Other Indicators*	*Phase I Baseline Perc.*	*Phase I Final Perc.*	*Stat. Sig?*	*Phase II Baseline Perc.*	*Phase II Final Perc.*	Stat. Sig.?
94	**Received health msg last month from TV**	**-**	**17.7%**		**-**	6.1%	
95	**Received health msg last month from Leader Mother**	**-**	**80.3%**		**-**	77.8%	
96	**Received health msg last month from other CHW**	**-**	**48.5%**		**-**	55.1%	
97	**Received health msg last month from either LM or other CHW (may have confused titles)**	**-**	**88.4%**		**-**	85.4%	

Food Category	**Area A**				**Area B**			
	Baseline Perc.	Final Perc.	Base to Final Diff.	Stat. Sig?	Baseline Perc.	Final Perc.	Base to Final Diff.	Stat. Sig?
Commercially-produced infant formula	**2%**	**9%**	**7%**	**Y**	**1%**	**6%**	**5%**	N
Fruit juice	**18%**	**39%**	**21%**	**Y**	**22%**	**39%**	**18%**	**Y**
Tea or coffee (including herbal teas)	**4%**	**29%**	**25%**	**Y**	**15%**	**25%**	**11%**	N
Commercially-fortified baby food	**1%**	**6%**	**5%**	**Y**	**1%**	**4%**	**3%**	N
Bread, rice, noodles, biscuits, cookies, or any other food made from grains	**69%**	**87%**	**19%**	**Y**	**46%**	**87%**	**41%**	**Y**
White potatoes, white yams, manioc, cassava, or other foods made from roots	**2%**	**15%**	**13%**	**Y**	**17%**	**36%**	**19%**	**Y**
Carrots, squash or sweet potatoes that are yellow or	**5%**	**22%**	**17%**	**Y**	**13%**	**36%**	**23%**	**Y**

orange inside								
Dark green leafy vegetables	**23%**	**40%**	**17%**	**Y**	**31%**	**44%**	**14%**	N
Other fruits or vegetables	**4%**	**30%**	**25%**	**Y**	**8%**	**38%**	**31%**	**Y**
Chicken, duck or other foul	**1%**	**6%**	**5%**	**Y**	**10%**	**8%**	**-2%**	N
Eggs	**1%**	**15%**	**14%**	**Y**	**15%**	**13%**	**-1%**	N
Fresh or dried fish or shellfish	**14%**	**32%**	**19%**	**Y**	**15%**	**35%**	**20%**	**Y**
Foods made from beans, peas, or lentils	**11%**	**15%**	**5%**	N	**6%**	**19%**	**13%**	**Y**
Nuts	**0%**	**16%**	**16%**	**Y**	**3%**	**9%**	**6%**	N
Food made with other oil, fat or butter	**5%**	**42%**	**36%**	**Y**	**12%**	**49%**	**37%**	**Y**
3+ meals/snacks consumed past day	**35%**	**64%**	**29%**	**Y**	**37%**	**59%**	**22%**	**Y**
Added oil to meal	**34%**	**86%**	**52%**	**Y**	**61%**	**89%**	**28%**	**Y**

C. Program Code used for Analysis

1. Questionnaire Analysis

```
** FOOD FOR THE HUNGRY INTERNATIONAL - MOZAMBIQUE
** Child Survival Baseline Survey (dev:2/28/06) Epi-Info Analysis Program
** Written by Tom Davis, MPH, Senior Director of Health Programs, FH
** Updated July 9, 2010 for final evaluation questionnaire

READ ?Data drive/file (ej., "d:CSBASE1.REC"):  ?

* This next line will prompt you during analysis for where
* you want the results to be sent.  There are 3 possibilities:
```

```
* screen, printer, or {filename}.  If you route to a file, type in
* the entire directory and filename (e.g."c:\epi6\data\indic17.txt")
* To route it to the printer, simply type "printer" and hit enter.
ROUTE ?Send the results to ... (SCREEN, PRINTER, {filename}): ?
*
* Can set this to no pause when you want to route to the screen
* but do not want the program to pause during output
set pause=on

* This next line sets the printer to HP
SET PRINTER = HP

*These next two lines give a header to each page.
HEADER 1 \cResults of CS Final KPC Study, FH-Mozambique
HEADER 2 \cJuly 2010

** Routing
******************
GOTO BASICFREQ
GOTO RAPIDCATCH
GOTO GENTABLES
GOTO MOMAGETAB
GOTO END

******************
:BASICFREQ
?Type SELECT to run basic frequencies and RETURN to not run basic
frequencies: ?
ROUTE ?Send the results to ... (SCREEN, PRINTER, {filename}): ?
```

```
* Frequencies

Title 1 Entrevistadores

Freq ENTREVIST


Title 1 Supervisores

Freq SUPERVIS


Title 1 Datas de Entrevistas

Freq DATENTR


Title 1 Distritos

Freq DISTRITO


Title 1 Areas de Supervisao

Freq AREASUP


Title 1 1. Si a mae desta crianca vive com a crianca

Freq MAEVIVE /CI


Title 1 2. Qual a sua relacao com esta crianca

Freq RELAC /CI


Title 1 2(esp). Relacao com esta crianca (especifique)

Freq N2ESPEC


Title 1 3. Que idade tens (Respondente)

Freq IDADRESP /CI


Title 1 4. GENERO DO RESPONDENTE
```

```
Freq GENRESP /CI

Title 1 5. Criancas que moram nesta casa (<5)

Freq CRIANMORA

Title 1 6. Criancas que sao suas criancas biologicas

Freq SUASCRIAN

Title 1 7. Sexo da tua crianca (#1)

Freq GEN1CRIAN

Title 1 7. Idade da tua crianca (#1)

DEFINE IDADCRIA1 ##.#

IDADCRIA1 = (DATENTR-NASC1CRIAN)/(365/12)

If NASC1CRIAN = . then IDADCRIA1 = .

Freq IDADCRIA1

Title 1 7. Sexo da tua crianca (#2)

Freq GEN2CRIAN

Title 1 7. Idade da tua crianca (#2)

DEFINE IDADCRIA2 ##.#

IDADCRIA2 = (DATENTR - NASC2CRIAN)/(365/12)

Freq IDADCRIA2

Title 1 Average Child Spacing (months)

DEFINE ESPACCRIA ##.#

ESPACCRIA = IDADCRIA2 - IDADCRIA1

If IDADCRIA1 = . then ESPACCRIA = .
```

```
If IDADCRIA2 = . then ESPACCRIA = .

** Check with MCHP to see if these next two lines should be here.

If ESPACCRIA < 0 then ESPACCRIA = (IDADCRIA1 - IDADCRIA2)

** Put this in because last blank entry seems to be generating a value of
1309.

If ESPACCRIA > 1000 then ESPACCRIA = .

Means ESPACCRIA


Title 1 8. Idade (em meses) da NOME (por data de nascimento)

DEFINE IDADECRIA ##.#

IDADECRIA = (DATENTR - NASCCRIAN)/(365/12)

If NASCCRIAN = . then IDADECRIA = .

Means IDADECRIA


Title 1 9. Idade (em meses) da NOME (mother's report)

Means IDADECRIAN


Title 1 \lNumber of questionnaires in which the DOB

Title 2 \land Age in Months Reported May Not Coincide

Define AGECHILDIF <A    >

AGECHILDIF = "NON"

If ((IDADECRIA - IDADECRIAN) > 1) then agechildif = "POSIB"

If IDADECRIA = . then agechildif = "NON"

If IDADECRIAN = . then agechildif = "NON"

If IDADENS = "S" then agechildif = "NON"

Freq AGECHILDIF


Title 1 9a. Sexo da NOME

Title 2 (1 = Masculino; 2 = Feminino; 9= Nao Sabe/Nenhuma Resposta)

Freq GENCRIA
```

Title 2

Title 1 10. Durante quantos anos Respondente frequentou a escola

If FREQESCOL = 99 then FREQESCOL = .

Freq FREQESCOL /CI

Title 1 11. Essa pessoa (who watches name) ouviu os ensinos da Mae chefe

Freq FORAEDUC /CI

Title 1 12. Principal fonte de gua de beber

Freq PRINFONTE /CI

Title 1 12. Principal fonte de gua de beber (Especifique)

* Left this variable name like this since it was like this in the template

Freq N17OUTRO

Title 1 13. O respondente fez qualquer coisa a agua dada a (NOME) para

Title 2 torna-la segura para beber (crianzas > 5m)

Select IDADECRIAN > 5

Title 3 A. NAO FEZ NADA / NAO TRATOU AGUA

* Left these variable names like this since they were like this in template

Freq N19A

Title 3 B. FERVEU A AGUA

Freq N19B /CI

Title 3 C. ADICIONOU JAVEL / CLORO NA AGUA

Freq N19C /CI

Title 3 D. USOU UM PRODUTO COMERCIAL PARA PUR. DE AGUA (ex., CERTEZA)

Freq N19D /CI

Title 3 E. FILTROU ATRAVES DUM PANO LIMPO

Freq N19E /CI

Title 3 F. USOU UM FILTRO DE AGUA (ceramica, areia, composto)

Freq N19F /CI

Title 3 G. USOU DESINFECCAO SOLAR (deixou no sol)

Freq N19G /CI

Title 3 H. USOU SEDIMENTACAO (deixou assim e sedimento…)

Freq N19H /CI

Title 3 X. OUTRO

Freq N19X /CI

Title 3 X. OUTRO (ESPECIFIQUE)

FREQ N19XESPEC

Title 2

Title 3

Title 1 (Calculated) Mother used some effective form of H20 purification

Title 2 (Children > 5m)

Define GOODPURIF <Y>

GOODPURIF = "N"

If N19B = "Y" then GOODPURIF = "Y"

If N19C = "Y" then GOODPURIF = "Y"

```
If N19D = "Y" then GOODPURIF = "Y"

If N19F = "Y" then GOODPURIF = "Y"

If N19G = "Y" then GOODPURIF = "Y"

Freq GOODPURIF /CI

Title 2

Select


Title 1 14. Onde foi que (NOME) defecou

Freq ONDEDEFEC /CI


Title 1 14, esp. Onde foi que (NOME) defecou (Especifique)

Freq N14ESPEC


Title 1 Child defecated proper place

Define GOODPOTTY <Y>

GOODPOTTY = "N"

If ((ONDEDEFEC > 0) and (ONDEDEFEC < 5)) then GOODPOTTY = "Y"

Freq GOODPOTTY /CI


Title 1 15. A casa do Respondente tem um lugar especial para lavar os mãos

Freq LUGARLAVAR /CI


Title 1 16. PECA PARA VER ... OBSERVA SE OS SEGUINTES ITENS ESTAO PRESENTES:

Title 2 A. AGUA/TORNIERA

Freq TENAGUA /CI


Title 2 B. SABAO, CINZA, OUTRO AGENTE

Freq TENSABAO /CI
```

Title 2 C. BACIA

Freq TENBACIA /CI

Title 2

Title 1 Respondent has water, soap and basin

DEFINE WATSUPPLIES <Y>

WATSUPPLIES = "N"

If ((TENAGUA=1) AND ((TENSABAO=1) AND (TENBACIA=1)) then WATSUPPLIES="Y"

Freq WATSUPPLIES

Title 1 17. Quando o respondente lava suas maos com sabao/cinza:

Title 2 A. NAO SABE/NENHUMA RESPOSTA

Freq N17A /CI

Title 2 B. NUNCA

Freq N17B /CI

Title 2 C. ANTES DE PRERARACAO DA COMIDA

Freq N17C /CI

Title 2 D. ANTES DE DAR DE COMER AS CRIANÇAS

** When mom said “before eating” or “before feeding family” marked this one

Freq N17D /CI

Title 2 E. DEPOIS DE DEFECAR

Freq N17E /CI

Title 2 F. DEPOIS DE CUIDAR DE UMA CRIANÇA QUE DEFECOU

Freq N17F /CI

Title 2 X. OUTRO

Freq N17X /CI

Title 2 X. OUTRO (Especifique)

FREQ N17XESPEC

Title 2

Title 1 18. O Respondente recebeu uma injecca no braço para prevenir

Title 2 o bebe de apanhar tetano

Freq IJECAOTT /CI

Title 2

Title 1 19. Quantas vezes voce recebeu tal injeccao (TT)

** Set to 0 if mother does not remember

If VECESTT = 9 then VECESTT = 0

Freq VECESTT /CI

Title 1 19b. Quando deu a luz a (NOME), recebeu em sua casa visita da MC

Title 2 ou de um trabalhador de saúde durante a PRIMEIRA SEMANA depois do parto

Freq MCPRIMSEM /CI

Title 2

Title 1 20. Quem o ajudou o Respondente com parto de (NOME)

Title 2 A. NAO SABE/NAO SE LEMBRA/NENHUMA RESPOSTA

Freq N20A /CI

Title 2 B. MEDICO

Freq N20B /CI

Title 2 C. ENFERMEIRA/PARTEIRA

Freq N20C /CI

Title 2 D. ASSISTENTE DE PARTEIRA

Freq N20D /CI

Title 2 E. PARTEIRA TRADICIONAL

Freq N20E /CI

Title 2 F. TRABALHADOR DE SAUDE DA COMUNIDADE

Freq N20F /CI

Title 2 G. MEMBRO DA FAMILIA

Freq N20G /CI

Title 2 G. MEMBRO DA FAMILIA (Especifique)

FREQ N20GESP

Title 2 H. NINGUEM

Freq N20H /CI

Title 2 X. OUTRO

Freq N20X /CI

Title 2 X. OUTRO (Especifique)

FREQ N20XESP

Title 2

Title 1 21. Durante quantos dias o Respondente tomou suplementos ferreos

Title 2 (of mothers who remembered)

** Might want to change this to "0" rather than blank.

If SUPFERR = 99 then SUPFERR = .

Freq SUPFERR /CI

Title 1 22. Months of antenatal care received

** Might want to change this to "0" rather than blank.

If CONSPRENS = "S" then CONSPREN = .

Freq CONSPREN /CI

Title 2

Title 1 23. O Respondente alguma vez amamentou (NOME)

Freq AMAMENTOU /CI

Title 1 24. Quanto tempo apos o parto o Respondente pos (NOME) a mamar

Freq POSAMAMAR /CI

Title 1 25. Durante os primeiros tres dias apos o parto, o Respondente

Title 2 deu a (NOME) o liquido que saia dos seus seios

Freq PPDEUSEIO /CI

Title 1 26. Durante os primeiros tres dias apos o parto, o Respondente

Title 2 deu a (NOME) qualquer outra coisa para comer ou beber

Freq PPDEULIQ /CI

Title 2

Title 1 27. O que o Respondente deu a (NOME) durante os primeiros

Title 2 tres dias apos o parto para comer ou beber

Title 3 A. NAO SABE/NENHUMA RESPOSTA

Freq N27A /CI

Title 3 B. LEITE (PARA ALEM DE AMAMENTACAO)

Freq N27B /CI

Title 3 C. SOMENTE AGUA/AGUA CLARA

Freq N27C /CI

Title 3 D. AGUA COM ACUCAR E/OU SAL

Freq N27D /CI

Title 3 E. SUMO DE FRUTA

Freq N27E /CI

Title 3 F. CHA/INFUSOES

Freq N27F /CI

Title 3 G. LIQUIDO OU SEMI-LIQUIDO TRADICIONAL MEDICINA

Freq N27G /CI

Title 3 H. FORMULA INFANTIL

Freq N27H /CI

Title 3 X. OUTRO

Freq N27X /CI

Title 3 X. OUTRO (Especifique)

FREQ N27XESP

Title 2

Title 3

Title 1 28. O Respondente esta actualmente a amamentar a (NOME)

Title 2

Freq ACTAMAMEN /CI

Title 1 Children 6-11m Still Breastfeeding

select idadecrian > 5

select idadecrian < 12

freq ACTAMAMEN

Select

Title 1 29. Por quanto tempo o Respondente amamentou a (NOME)

If TIEMPOAMAM = 99 then TIEMPOAMAM = .

Freq TIEMPOAMAM /CI

Title 1 30. (NOME) bebeu dos seguintes liquidos ontem durante o dia e a noite

Title 2 A. Leite aterno

Freq N30A /CI

Title 2 B. Agua

Freq N30B /CI

Title 2 C. Forma infantil comercialmente produzido

Freq N30C /CI

Title 2 D. Qualquer outro leite de lado

Freq N30D /CI

Title 2 E. Sumo de Fruta

Freq N30E /CI

Title 2 F. Cha ou cafe

Freq N30F /CI

Title 2 G. Medicamentos tradicionais que eram liquido ou semi-liquido

Freq N30G /CI

Title 2 H. Maheu

Freq N30H /CI

Title 2 I. Qualquer outro liquido

Freq N30I /CI

Title 2 I. Qualquer outro liquido (Especifique)

FREQ N30ISPEC

Title 2 J. RESPONDENTE NAO MENCIONA LIQUIDO / NENHUMA RESPOSTA DADA

Freq N30J /CI

Title 1 31. (NOME) comeu das comidas seguintes ontem durante o dia ou a noite:

Title 2 A. Alguma sopa de aveia

Freq N31A /CI

Title 2 B. Qualquer COMIDA DE BEBE COMERCIALMENTE FORTALECIDA, ex. Cerelac]

Freq N31B /CI

Title 2 C. Qualquer pao, arroz, macarroes ...

Freq N31C /CI

Title 2 D. Qualquer batata branca, inhames brancos, ...

Freq N31D /CI

Title 2 E. Qualquer abobora, cenouras, abobora ...

Freq N31E /CI

Title 2 F. F. Qualquer legume verde escuro

Freq N31F /CI

Title 2 G. Qualquer manga madura ou papayas

Freq N31G /CI

Title 2 H. Qualquer outra fruta ou vegetais

Freq N31H /CI

Title 2 I. Qualquer figado, rim, coracao, ou outro orgao de carne

Freq N31I /CI

Title 2 J. Qualquer carne de boi, carne de porco, ...

Freq N31J /CI

Title 2 K. Qualquer galinha, pato, ou outras aves

Freq N31K /CI

Title 2 L. Qualquer ovos

Freq N31L /CI

Title 2 M. Qualquer peixe fresco ou secou ou mariscos

Freq N31M /CI

Title 2 N. Qualquer comida feita de feijoes, ervilhas, ou lentilas

Freq N31N /CI

Title 2 O. Qualquer nozes

Freq N31O /CI

Title 2 P. Qualquer quijo ou yogurte

Freq N31P /CI

Title 2 Q. Qualquer comida feita com outro oleo, gordura ou manteiga

Freq N31Q /CI

Title 2 R. Qualquer outra comida solida ou semi-solida

Freq N31R /CI

Title 2 S. RESPONDENTE NAO MENCIONOU NENHUMA COMIDA / NENHUMA RESPOSTA DAD

Freq N31S /CI

Title 2

Title 1 32. (NOME) bebeu qualquer coisa de um frasco com chucha

Freq CHUCHA /CI

Title 1 33. Quantas vezes a (NOME) comeu comidas solido, semi-solido, ou

Title 2 macias diferente de liquidos ontem durante o dia e noite

If VEZESCOMEU = 99 then VEZESCOMEU = .

Freq VEZESCOMEU /CI

Title 2

Title 1 34. Si o Respondente adicionou oleo a comida de (NOME)

Freq ADICOLEO /CI

Title 1 35. A (NOME) recebeu uma dose de vitamina A durante os ultimos 6 meses

Freq CRIANVITA /CI

Title 1 36. A (NOME) teve diarreia nas ultimas 2 semanas

Freq DIARREIA /CI

Title 1 37. O que foi dado para tratar a diarreia o desidratacao:

Title 2 A. NAO SABE/NENHUMA RESPOSTA

Freq N37A /CI

Title 2 B. NADA

Freq N37B /CI

Title 2 C. PILULA OU XAROPE

Freq N37C /CI

Title 2 D. INJECCOES

Freq N37D /CI

Title 2 E. LIQUIDOS INTRAVENOSOS IV

Freq N37E /CI

Title 2 F. REMEDIOS CASEIROS/MEDICAMENTOS HERBARIOS …

Freq N37F /CI

Title 2 G. FLUIDO DOS PACOTES DE SRO

Freq N37G /CI

Title 2 H. FLUIDOS CASEIROS RECOMENDADOS – AGUA, SUMO, ETC.

Freq N37H /CI

Title 2 X. OUTRO

Freq N37X /CI

Title 2 X. OUTRO (Especifique)

FREQ N37XESP

Title 1 38. O Respondente amamentou a (NOME) menos que o habitual, a mesma

Title 2 quantidade, ou mais que o habitual

Freq DIARMASAM /CI

Title 1 39. (NOME) foi oferecido menos que o habitual, a mesma quantidade

Title 2 ou mais que o habitual para beber

Freq DIARMASLIQ /CI

Title 1 40. (NOME) foi oferecida menos que o habitual para comer, cerca da

Title 2 mesma quantidade, ou mais que o habitual para comer

Freq DIARMASCOM /CI

Title 1 41. Durante as semanas depois de (NOME) teve diarr,ia, o Respondente

Title 2 geralmente deu a ele/ela menos que habitual para comer, ...

Freq DIARMASDEP /CI

Title 2

Title 1 42. Knows how to prepare ORS correctly (1=Yes)

Freq FALARSRO /CI

Title 1 43. Os sinais de doenca que indicariam que sua crianca precisa

Title 2 de tratamento

Title 3 A. NAO SABE/NENHUMA RESPOSTA

Freq N43A /CI

Title 3 B. PARECE INDISPOSTA OU NAO BRINCANDO NORMALMENTE

Freq N43B /CI

Title 3 C. NAO COMENDO OU BEBENDO

Freq N43C /CI

Title 3 D. LETARGICO OU DIFICIL SE DESPERTAR

Freq N43D /CI

Title 3 E. FEBRE ALTA

Freq N43E /CI

Title 3 F. RESPIRACAO RAPIDA OU DIFICIL

Freq N43F /CI

Title 3 G. VOMITA TUDO

Freq N43G /CI

Title 3 H. CONVULCOES

```
Freq N43H /CI

Title 3 I. OUTRO
Freq N43I /CI

Title 3 I. OUTRO (ESPECIFIQUE)
FREQ N43ISPEC

Title 3 J. OUTRO
Freq N43J /CI

Title 3 J. OUTRO (ESPECIFIQUE)
FREQ N43JSPEC

Title 3 L. OUTRO
Freq N43L /CI

Title 3 L. OUTRO (Especifique)
FREQ N43LSPEC
Title 2
Title 3

Title 1 (Calc. based on #43) Average Number of IMCI Signs Known
Define IMCISIGNS ##
IMCISIGNS = 0
If N43B = "Y" then IMCISIGNS = IMCISIGNS + 1
If N43C = "Y" then IMCISIGNS = IMCISIGNS + 1
If N43D = "Y" then IMCISIGNS = IMCISIGNS + 1
If N43E = "Y" then IMCISIGNS = IMCISIGNS + 1
```

```
If N43F = "Y" then IMCISIGNS = IMCISIGNS + 1

If N43G = "Y" then IMCISIGNS = IMCISIGNS + 1

If N43H = "Y" then IMCISIGNS = IMCISIGNS + 1

Freq IMCISIGNS


Title 1 44. O Respondente tem alguma rede de cama em sua casa

Freq TEMREDE /CI


Title 2 45. Quem dormiu ontem à noite debaixo de uma rede de cama:

Title 2 A. CRIANCA (NOME)

Freq N45A /CI


Title 2 B. O RESPONDENTE

Freq N45B /CI


Title 2 C. OUTRO INDIVIDUO(S)

Freq N45C /CI

Title 2


Title 1 46. A rede de cama foi alguma vez saturada

Freq REDESATUR /CI


Title 1 47. O que a pessoa pode fazer para evitar contrair o SIDA

Title 2 A. NADA

Freq N47A /CI


Title 2 B. ABSTER-SE DO SEXO

Freq N47B /CI
```

Title 2 C. USE PRESERVATIVOS

Freq N47C /CI

Title 2 D. LIMITE O SEXO PARA UM PARCEIRO/ FICAR FIEL A UM PARCEIRO

Freq N47D /CI

Title 2 E. LIMITE O NUMERO DE PARCEIROS SEXUAIS

Freq N47E /CI

Title 2 F. EVITE SEXO COM PROSTITUTAS

Freq N47F /CI

Title 2 G. EVITE SEXO COM UMA PESSOA QUE TEM MUITOS PARCEIROS

Freq N47G /CI

Title 2 H. EVITE RELACIONAMENTO COM PESSOAS DO MESMO SEXO

Freq N47H /CI

Title 2 I. EVITE SEXO COM PESSOAS QUE INJETAM DROGA INTRAVENOSA

Freq N47I /CI

Title 2 J. EVITE TRANSFUSOES DE SANGUE

Freq N47J /CI

Title 2 K. EVITE INJECCOES

Freq N47K /CI

Title 2 L. EVITE BEIJOS

Freq N47L /CI

Title 2 M. EVITE MORDIDAS DE MOSQUITO

Freq N47M /CI

Title 2 N. BUSQUE PROTECAO DE CURANDEIRO TRADICIONAL

Freq N47N /CI

Title 2 O. EVITE COMPARTILHAR NAVALHAS, LAMINAS,

Freq N47O /CI

Title 2 W. OUTRO

Freq N47W /CI

Title 2 W. OUTRO, Especifique

FREQ N47WSPEC

Title 2 X. OUTRO

Freq N47X /CI

Title 2 X. Outro, Especifique

FREQ N47XSPEC

Title 2 Z. NAO SABE

Freq N47Z /CI

Title 1 (Calc. using #47) Average number of correct ways to prevent HIV

Title 2 Known by Mothers

Define HIVKNOWL ##

```
HIVKNOWL = 0
If N47B = "Y" then HIVKNOWL = HIVKNOWL + 1
If N47C = "Y" then HIVKNOWL = HIVKNOWL + 1
If N47D = "Y" then HIVKNOWL = HIVKNOWL + 1
If N47E = "Y" then HIVKNOWL = HIVKNOWL + 1
If N47F = "Y" then HIVKNOWL = HIVKNOWL + 1
If N47G = "Y" then HIVKNOWL = HIVKNOWL + 1
If N47H = "Y" then HIVKNOWL = HIVKNOWL + 1
If N47I = "Y" then HIVKNOWL = HIVKNOWL + 1
If N47J = "Y" then HIVKNOWL = HIVKNOWL + 1
** Next line sets to blank if respondent is not mother
If RELAC <> 1 then HIVKNOWL = .
Freq HIVKNOWL /CI
Title 2

Title 1 48. O (NOME) tem um cartão de monitora crescimento
Freq TEMCARTCRE /CI

Title 1 49. Se (NOME) foi pesada nos primeiros dois meses de vida
Freq PESACEDO /CI

Title 1 50. Se (NOME) foi pesada nos ultimos quatro meses
Freq PRESQUAT /CI

Select IDADECRIAN > 11
Title 1 51. Se (NOME) recebeu um medicamento para lombrigas (ult. 6m)
Title 2 (Children > 11m)
Freq MEDICLOMB /CI
Select
```

Title 2

Title 1 52. Depois de dar à luz, recebeu uma dose de vitamina A

Freq MAEVITA

Title 1 53. Quanto tempo após você dar a luz a (Nome) foi lhe

Title 2 dada a dose de vitamina A

Freq MAEVITMES

Title 2

Title 1 (Calc. based on #53) Mother received Vit A within 2m

Define VITA2M <Y>

VITA2M = "N"

** Decide how to handle missing data

If (MAEVITA = 1) and (MAEVITMES = 1) then VITA2M = "Y"

Freq VITA2M

Title 1 54. Mother knows danger signs after delivery

Title 2 A: Fever

Freq N54A /CI

Title 2 B: Excessive Bleeding

Freq N54B /CI

Title 2 C: Bad odor in vaginal secretion

Freq N54C /CI

Title 2 D: Doesn’t know / no response

Freq N54D /CI

Title 2 X: Other CORRECT

Freq N54X /CI

Title 2 X, Specify (Correct and Incorrect)

FREQ N54XESP

Title 2

Title 1 55. Da ambos os seios

Freq AMBOSEIOS /CI

Title 1 56. Esvazia completamente ambos seios

Freq ESVAZIA /CI

Title 1 57. Como conserva a comida

Title 2 (1 = Covered or refrigerated)

Freq CONSCOMID /CI

Title 2

Title 1 58. Voce recebeu visita da Mae Lider ultimas duas semanas

Freq VISMC /CI

Title 1 59. Quanto tempo depois da criança nascer a mãe deveria

Title 2 levar para começar a amamentar

Freq CONCOMAM /CI

Title 2

Title 1 60. você esta a prejudica de alguma maneira a sua criança

Title 2 se a amamenta durante uma nova gravidez

Freq PREJUDAM /CI

Title 2

Title 1 61. Who is more valuable, men or women

Title 2 (1=Men; 2=Women; 3=Both equal value)

Freq MAISVALOR /CI

Title 2

Title 1 62. How to BF when HIV+

Title 2 (1: Only breast, no foods-liquids; 2: mixed feeding 3: other incorr.)

Freq AMAHIV /CI

Title 2

Title 1 63. How can a mother prevent anemia during pregnancy

Title 2 1: Comer comidas ricas em ferro

Freq N631

Title 2 2: Comer sal iodado

Freq N632

Title 2 3: Tomar suplementos com ferro e acido folico

Freq N633

Title 2 4: Dormir de baixo da rede mosquiteira

Freq N634

Title 2 9: Don’t know / No response

Freq N639

Title 2

Title 1 64. Child has had fever in last two weeks

Freq FEBRES /CI

Title 1 65. Sought care for fever (1=yes)

Title 2 (of children who had fever)

Select FEBRES=1

Freq FEBACON /CI

Select

Title 1 66. Where care was sought for fever

Title 2 (of children who had fever)

Select FEBRES=1

Title 3 A: Curandeiro Tradicional

Freq N66A /CI

Title 3 B: Hospital do Governo

Freq N66B /CI

Title 3 C: Unidade Sanitaria

Freq N66C /CI

Title 3 D: Lideres Religiosas

Freq N66D /CI

Title 3 E: Medicao/Enfermeiro Privado

Freq N66E /CI

Title 3 F: Famacias

Freq N66F /CI

Title 3 G: Mae Chefe treinada em AIDA-C

Freq N66G /CI

Title 3 H: Mae Chefe no treinada em AIDA-C

Freq N66H /CI

Title 3 I: Parteira Tradicional

Freq N66I /CI

Title 3 I: Parentes ou Amigos

Freq N66J /CI

Title 3 K: No Sabe / Nenhuma Reposta

Freq N66K /CI

Title 2

Title 3

Select

Title 1 O que provoca Malaria

Title 2 A: Picada de um mosquita

Freq N67A /CI

Title 2 B: Feiticaria

Freq N67B /CI

Title 2 C: Uso de drogas intravenosas

Freq N67C /CI

Title 2 D: Transfusao de sangue

Freq N67D /CI

Title 2 E: Injeccoes

Freq N67E /CI

Title 2 F: Partilha de laminas

Freq N67F /CI

Title 2 G: Tosse

Freq N67G /CI

Title 2 H: Outro

Freq N67H /CI

Title 2 H, Specify

FREQ N67HESP

Title 2 I: Don’t know / No response

Freq N67I /CI

Title 2

Select IDADECRIAN > 11

Title 1 68. Doses da vacina DPT registradas, >11m

Title 2 Of children with card

Freq DOSESDPT /CI

Select

```
Select IDADECRIAN > 11
Title 1 68. Doses da vacina DPT registradas, >11m
Title 2 Of all children (lost card = 0 doses)
Define TEMPDPT #
TEMPDPT = DOSESDPT
If FALTACAR1 = "3" then TEMPDPT = 0
Freq TEMPDPT /CI
Select

Title 1 68fc. Falta Cartao
Title 2 (All children)
Freq FALTACAR1 /CI
Title 2

Select IDADECRIAN > 11
Title 1 68fc. Falta Cartao
Title 2 (Children > 11m)
Freq FALTACAR1 /CI
Select
Title 2

Select IDADECRIAN > 11
Title 1 68b. Recebeu vacina de sarampo
Title 2 Of those with card (1=YES; 2=NO; 3= NO CARD)
Freq DOSESAR /CI
Select

Select IDADECRIAN > 11
Title 1 68b. Recebeu vacina de sarampo
```

Title 2 Of all children (lost card = 0 doses; 1=Y; 2=N; 3=No Card)

If FALTACAR1 = "3" then DOSESAR = 0

Freq DOSESAR /CI

Select

Title 2

Title 1 69. Com que frecquencia voce entrou em contato con

Title 2 A: Doutor

Freq N69A /CI

Title 2 B: Enfermeira ou Partiera treninada

Freq N69B /CI

Title 2 C: Mae Chefe, Educ Saude / TS

Freq N69C /CI

Title 2 D: Parteira tradicional

Freq N69D /CI

Title 2 E: Curandeiro tradicional

Freq N69E /CI

Title 2

Title 1 70. De onde obtem informacao geral ou aconselhmaneto, saude/nut.

Title 2 A: Doutor

Freq N70A /CI

Title 2 B: Enfermeria / Parteira Treinada

Freq N70B /CI

Title 2 C: Mae Chefe / Educ Saude / TS

Freq N70C /CI

Title 2 D: Parteira tradicional

Freq N70D /CI

Title 2 E: Marido / Parceiro

Freq N70E /CI

Title 2 F: Mae / Sogra

Freq N70F /CI

Title 2 G: Irao

Freq N70G /CI

Title 2 H: Avo

Freq N70H /CI

Title 2 I: Tia

Freq N70I /CI

Title 2 J: Amigo / Vizinho

Freq N70J /CI

Title 2 K: Curandeiro Tradicional

Freq N70K /CI

Title 2 L: Anciao de Aldeia

Freq N70L /CI

Title 2 X: Outro

Freq N70X /CI

Title 2 X, Specify

FREQ N70XESP

Title 2

Title 1 71. No ultimo mes, recebeu aluma mensagem de saude de

Title 2 A: Radio

Freq N71A /CI

Title 2 B: Jornal

Freq N71B /CI

Title 2 C: Televisao

Freq N71C /CI

Title 2 D: Mae de Lider

Freq N71D /CI

Title 2 E: Outro Educ Saude / TS

Freq N71E /CI

Title 2

Title 1 72. Possa pesar (NOME)

Freq POSSAPESAR /CI

```
Title 1 71. Genero da CRIANCA #1 (NOME)
Freq GENERO1 /CI

** Looks at whether this age matches Nome's age
Title 1 71. Idade da CRIANCA #1 (NOME)
Define IDADPES1 ##
IDADPES1 = (DATNASC1 - DATENTR)/(365/12)
IDADPES1 = TRUNC(IDADPES1)
If DATNASC1 = . then IDADPES1 = IDADECRIAN
If IDADPES1 < 0 then IDADPES1 = .
Define IDADPES2 ##
IDADPES2 = (DATNASC2 - DATENTR)/(365/12)
IDADPES2 = TRUNC(IDADPES2)
If IDADPES2 < 0 then IDADPES2 = .
Define IDADPES3 ##
IDADPES3 = (DATNASC3 - DATENTR)/(365/12)
IDADPES3 = TRUNC(IDADPES3)
If DATNASC2 = . then IDADPES2 = .
If IDADPES3 < 0 then IDADPES3 = .
Define IDADPES4 ##
IDADPES4 = (DATNASC4 - DATENTR)/(365/12)
IDADPES4 = TRUNC(IDADPES4)
If DATNASC4 = . then IDADPES4 = .
If IDADPES4 < 0 then IDADPES4 = .

Title 1 Agreement between DOB in Anthro Section (Child #1)
Title 2 and DOB recorded at beginning of Survey (estimate)
Define DOBMATCH <Y>
DOBMATCH = "Y"
```

```
If DATNASC1 <> NASCCRIAN THEN DOBMATCH = "N"

Freq DOBMATCH


* Indicadores do Projecto

Title 1 Percentage of infants aged 0-5 months who were fed breastmilk only

Title 2 in the last 24 hours (Project + RapidCATCH indicator)

Select IDADECRIAN < 6

Define EXCBF <Y>

IF N30A = "Y" THEN EXCBF = "Y"

IF N30B = "Y" THEN EXCBF = "N"

IF N30C = "Y" THEN EXCBF = "N"

IF N30D = "Y" THEN EXCBF = "N"

IF N30E = "Y" THEN EXCBF = "N"

IF N30F = "Y" THEN EXCBF = "N"

IF N30G = "Y" THEN EXCBF = "N"

IF N30H = "Y" THEN EXCBF = "N"

IF N30I = "Y" THEN EXCBF = "N"


If N31A = "Y" then EXCBF = "N"

If N31B = "Y" then EXCBF = "N"

If N31C = "Y" then EXCBF = "N"

If N31D = "Y" then EXCBF = "N"

If N31E = "Y" then EXCBF = "N"

If N31F = "Y" then EXCBF = "N"

If N31G = "Y" then EXCBF = "N"

If N31H = "Y" then EXCBF = "N"

If N31I = "Y" then EXCBF = "N"

If N31J = "Y" then EXCBF = "N"

If N31K = "Y" then EXCBF = "N"
```

```
If N31L = "Y" then EXCBF = "N"
If N31M = "Y" then EXCBF = "N"
If N31N = "Y" then EXCBF = "N"
If N31O = "Y" then EXCBF = "N"
If N31P = "Y" then EXCBF = "N"
If N31Q = "Y" then EXCBF = "N"
If N31R = "Y" then EXCBF = "N"
Freq EXCBF /CI
Select

Title 1 Percentage of children 9-23m who receive food other than liquids
Title 2 at least three times per day (Project Indicator)
Select IDADECRIAN > 8
Define N3MEALS <A>
If VEZESCOMEU > 2 then N3MEALS = "S"
If VEZESCOMEU < 3 then N3MEALS = "N"
If VEZESCOMEU = . then N3MEALS = "."
If VEZESCOMEU = 99 then N3MEALS = "."
Freq N3MEALS /CI
Select

Title 1 Percentage of children 6-23 months of age with oil added to
Title 2 their weaning food (Project Indicator)
Select IDADECRIAN > 5
Freq ADICOLEO /CI
Select

Title 1 Percentage of children 6-23m who have consumed at least one
Title 2 Vitamin A rich food in the previous day (Project Indicator)
```

```
Define VITAFOODS <A>
VITAFOODS = "N"
Select IDADECRIAN > 5
If N31E = "Y" then VITAFOODS = "S"
If N31F = "Y" then VITAFOODS = "S"
If N31G = "Y" then VITAFOODS = "S"
If N31I = "Y" then VITAFOODS = "S"
If N31J = "Y" then VITAFOODS = "S"
If N31K = "Y" then VITAFOODS = "S"
If N31L= "Y" then VITAFOODS = "S"
Freq VITAFOODS /CI
Select

Title 1 Percentage of children 12-23 months of age who have received one
Title 2 Vitamin A capsule in the past six months (Project Indicator)
Select IDADECRIAN > 11
Define VITARECV <A>
VITARECV = "N"
IF CRIANVITA = 1 then VITARECV = "S"
Freq VITARECV /CI
Select

Title 1 Percentage of children 12-23 months who received deworming medication
Title 2 in the last six months (Project Indicator)
Select IDADECRIAN > 11
Freq MEDICLOMB /CI
Select

Title 1 Percentage of children aged 0-23 months who were weighed in the
```

```
Title 2 last four months (card-confirmed) (Project Indicator)

Title 3 of mothers that have a card available

Define WEIGHED4 <A>

WEIGHED4 = "N"

If ((TEMCARTCRE=1) and (PRESQUAT=1)) then WEIGHED4 = "S"

If TEMCARTCRE = 2 then WEIGHED4 = "."

If TEMCARTCRE = 9 then WEIGHED4 = "."

Freq WEIGHED4 /CI

Select


Title 1 Percentage of children aged 0-23 months with diarrhea in the last

Title 2 two weeks who received oral rehydration solution (ORS) and/or

Title 3 recommended home fluids (RHF) (Project Indicator)

Select DIARREIA = 1

Define ORT <A>

ORT = "N"

If N37G = "Y" then ORT = "S"

If N37H = "Y" then ORT = "S"

Freq ORT /CI

Select

Title 2

Title 3


Title 1 Percent of children aged 0-23 months with diarrhea in the last two

Title 2 weeks who were offered the same amount or more food during the
illness

Select DIARREIA = 1

Define DIARFOOD <A>

DIARFOOD = "N"

If DIARMASCOM = 2 then DIARFOOD = "S"
```

```
If DIARMASCOM = 3 then DIARFOOD = "S"

If DIARMASCOM = 9 then DIARFOOD = "."

Freq DIARFOOD /CI

Select

Title 2

Title 3 (for children > 5m only)

Select idadecrian > 5

Freq diarfood /ci

Title 2

Title 3

select


Title 1 Percentage of mothers of children 0-23m who can correctly prepare ORS

Define PREPORS <A>

* Note rerun this command on baseline data - FALARSRO may be set "N" at
baseline

PREPORS = "N"

If FALARSRO = . then PREPORS = .

If FALARSRO = 1 then PREPORS = "S"

Freq PREPORS /CI


Title 1 Percentage of mothers of children age 0-23 months who know at least
two

Title 2 signs of childhood illness that indicate the need for treatment

Title 3 (Project + RapidCATCH Indicator)

Define IMCITWO <A>

IMCITWO = "N"

If IMCISIGNS > 1 then IMCITWO = "S"

Freq IMCITWO /CI

Title 2
```

```
Title 3


RETURN


:RAPIDCATCH


?Run RapidCATCH Indicators; SELECT = YES; RETURN = NO: ?

ROUTE ?Send the results to ... (SCREEN, PRINTER, {filename}): ?


** Rapid CATCH Indicators


Title 1 Percentage of children age 0-23 months who were born at least 24
months

Title 2 after the previous surviving child

Define GOODSPACE <A>

If ESPACCRIA > 23 then GOODSPACE = "S"

If ESPACCRIA < 24 then GOODSPACE = "N"

If ESPACCRIA = . then GOODSPACE = .

If SUASCRIAN = 1 then GOODSPACE = .

If SUASCRIAN = 9 then GOODSPACE = .

If RELAC <> 1 then GOODSPAC = .

Freq GOODSPACE /CI


Title 1 Percentage of children age 0-23 months whose births were attended

Title 2 by skilled health personnel

Define SKILLEDHP <A>

SKILLEDHP = "N"

** CHECK BASELINE SURVEY PGM - May have accepted DK/NR (A)

If N20B = "Y" then SKILLEDHP = "S"

If N20C = "Y" then SKILLEDHP = "S"
```

```
If N20D = "Y" then SKILLEDHP = "S"
If RELAC <> 1 then SKILLEDHP = .
Freq SKILLEDHP /CI

Title 1 Percentage of mothers with children age 0-23 months who received at
Title 2 least two TT injections before the birth of their youngest child
Define TWOTT <A>
TWOTT = "N"
If VECESTT >1 then TWOTT = "S"
If RELAC <> 1 then TWOTT = .
Freq TWOTT /CI

Title 1 Percentage of children age 6-9 months who received breastmilk and
Title 2 complementary foods during the last 24 hours
Select IDADECRIAN > 5
Select IDADECRIAN < 10
Define GOODCOMP <A>
If N31A= "Y" then GOODCOMP = "S"
If N31B = "Y" then GOODCOMP = "S"
If N31C = "Y" then GOODCOMP = "S"
If N31D = "Y" then GOODCOMP = "S"
If N31E = "Y" then GOODCOMP = "S"
If N31F = "Y" then GOODCOMP = "S"
If N31G = "Y" then GOODCOMP = "S"
If N31H = "Y" then GOODCOMP = "S"
If N31I = "Y" then GOODCOMP = "S"
If N31J = "Y" then GOODCOMP = "S"
If N31K = "Y" then GOODCOMP = "S"
If N31L = "Y" then GOODCOMP = "S"
```

```
If N31M = "Y" then GOODCOMP = "S"

If N31N = "Y" then GOODCOMP = "S"

If N31O = "Y" then GOODCOMP = "S"

If N31P = "Y" then GOODCOMP = "S"

If N31R = "Y" then GOODCOMP = "S"

If N30A = "N" then GOODCOMP = "N"

Freq GOODCOMP /CI

Select

Title 2


** Converts measles data – 1 in data set = first box checked for YES, etc.

DEFINE MEASLES <Y>

If DOSESAR = "1" then Measles = "Y"

If DOSESAR = "2" then MEASLES = "N"

If DOSESAR = "3" then MEASLES = "."


Title 1 Percentage of children age 12-23 months who are fully vaccinated

Title 2 (against the 5 vaccine-preventable diseases) before the first
birthday

Select IDADECRIAN > 11

Define ALLVACSYR <A>

ALLVACSYR = "N"

If ((DOSESDPT > 2) and (MEASLES = "Y")) then ALLVACSYR = "S"

Freq ALLVACSYR /CI

Select

Title 2


Title 1 Percentage of children age 12-23 months who are fully vaccinated

Title 2 (against the 5 vaccine-preventable diseases) before the first
birthday
```

```
Title 3 (Missing card = 0 doses)

Select IDADECRIAN > 11

Define TEMPDTP #

TEMPDTP = DOSESDPT

If FALTACAR1 = 3 then TEMPDTP = 0

Define ALLVACSYR2 <A>

ALLVACSYR2 = "N"

If ((TEMPDTP > 2) and (MEASLES = "Y")) then ALLVACSYR2 = "S"

Freq ALLVACSYR2 /CI

Select

Title 2

Title 3


Title 1 Percentage of children age 12-23 months who received a measles
vaccine

Select IDADECRIAN > 11

Freq MEASLES /CI

Select


Title 1 Percentage of children age 0-23 months who slept under an
insecticide-

Title 2 treated net (in malaria risk areas) the previous night

Define SLEPTITN <A>

SLEPTITN = "N"

If ((TEMREDE=1) AND (N45A="Y")) then SLEPTITN = "S"

Freq SLEPTITN /CI


Title 1 Percentage of mothers with children age 0-23 months who cite at least

Title 2 two known ways of reducing the risk of HIV infection

* Note:  Did not include "Avoid Injections" in the good responses
```

```
Define HIVTWO <A>

HIVTWO = "N"

If HIVKNOWL > 1 then HIVTWO = "S"

If HIVKNOWL = . then HIVTWO = "."

If RELAC <> 1 then HIVTWO = "."

Freq HIVTWO /CI


Title 1 Percentage of mothers with children age 0-23 months who report that
they

Title 2 wash their hands with soap/ash before [4 times]

Define GOODWASH <A>

GOODWASH = "N"

If ((N17C = "Y") and (N17D= "Y") and (N17E= "Y") and (N17F= "Y")) then \

GOODWASH = "S"

Freq GOODWASH /CI


Title 1 Percentage of sick children age 0-23 months who received increased

Title 2 fluids and continued feeding during an illness in the past two weeks

** NOTE - At final, this is based on children with diarrhea, not all
illnesses

Select DIARREIA = 1

Define GOODFEED <A>

GOODFEED = "N"

IF ((DIARMASLIQ = 3) and ((DIARMASCOM = 2) or (DIARMASCOM = 3))) then \

GOODFEED = "S"

Freq GOODFEED /CI

Title 2

Select


RETURN
```

```
:GENTABLES

?Run Gender Tables (cross-tabulations); SELECT = YES; RETURN = NO: ?


ROUTE ?Send the results to ... (SCREEN, PRINTER, {filename}): ?


Set percents = ON


Title 1 Diarrhea by Gender

Tables DIARREIA GENCRIA


RETURN


:MOMAGETAB

?Run Tables based on respondent's age; SELECT = YES; RETURN = NO: ?


ROUTE ?Send the results to ... (SCREEN, PRINTER, {filename}): ?


Define YOUNGRESP <A>

If IDADRESP = . then YOUNGRESP = .

If IDADRESP < 27 then YOUNGRESP = "S"

If IDADRESP >=27 then YOUNGRESP = "N"


Title 1 Children Exclusively Breastfed to 6 Months by Respondent’s Age

Tables EXCBF YOUNGRESP


Title 1 Children (9-23m) receiving Non-liquids Feeds 3+ Times/Day by Resp.
Age

Select IDADECRIAN > 8

Tables N3MEALS YOUNGRESP
```

Select

Title 1 Respondents w/children 6-23m adding weaning oil to child's food

Title 2 by Resp. Age

Select IDADECRIAN > 5

Tables ADICOLEO YOUNGRESP

Title 2

Select

Title 1 Children 12-23m receiving Vit A capsule in the past 6m by Resp. Age

Select IDADECRIAN > 11

Tables VITARECV YOUNGRESP

Select

Title 1 Children 12-23m receiving deworming meds in last 6m by Resp. Age

Select IDADECRIAN > 11

Tables MEDICLOMB YOUNGRESP

Select

Title 1 Children weighed in last 4m by Resp. Age

Tables WEIGHED4 YOUNGRESP

Title 1 Children w/diarrhea in last two weeks who received ORS and/or RHF

Title 2 by Respondent's Age

Tables ORT YOUNGRESP

Title 2

Title 1 Respondents who know at 2+ IMCI signs by Resp. Age

Tables IMCITWO YOUNGRESP

```
Title 1 Children fully immunized by first birthday by Resp. Age

Tables ALLVACSYR YOUNGRESP


Title 1 Children immunized against Measles by Resp. Age

Tables MEASLES YOUNGRESP


Title 1 Children who slept under an ITN by Resp. Age

Tables SLEPTITN YOUNGRESP


Title 1 Knowledge of HIV Prevention Methods (2+) by Resp. Age

Tables HIVTWO YOUNGRESP


Title 1 Handwashing (4 times) by Resp. Age

Tables GOODWASH YOUNGRESP


Title 1 Diarrhea by Resp. Age

Tables DIARREIA YOUNGRESP


Title 1 Good feeding during illness by Resp. Age

Tables GOODFEED YOUNGRESP


RETURN


:END
```

2. Anthropometric Analysis

```
* WAZFAM.PGM -- Program to analyze anthropometric data by giving number of
```

```
* children in each z-score range by age group, mean scores, and percentage
* for underweight children.
* Written by Tom Davis, MPH (Tom.Davis@fh.org)
* NOTE:  If child's age variable is not AGE in your data set, search and
* replace AGE in this program, renaming it with your variable name for
* weight.
* Modified 7/13/2010

read ?Location and name of Weight-Ages data file to analyze: ?

* This next line will prompt you during analysis for where
* you want the results to be sent.  There are 3 possibilities:
* screen, printer, or {filename}.  If you route to a file, type in
* the entire directory and filename (e.g."c:\epi6\data\indic17.txt")
* To route it to the printer, simply type "printer" and hit enter.
ROUTE ?Send the results to ... (SCREEN, PRINTER, {filename}): ?

* This next command gives you the option of turning on or off the pause that
* occurs when the output sent to the screen exceeds one screen.
Set Pause = ?Pause for ON or OFF:  ?
set criteria=off
* Change this next line if you are not using an epson/IBM-compatible printer
* If you are using an HP printer, change this to "set printer = HP".
set printer = EPSON
set pmode = 5

header 1 \c FH/Mozambique
header 2 \c Child Survival Final Evaluation July 2010
```

```
* Sets flagged records to blank
If WAZ = 9.99 then WAZ = .

* Removes outliers (per Epi-Info criteria)
Select WAZ < 6
Select WAZ > -6

* DEFINES CHILD AGE GROUPS AND Z-SCORE RANGES
define agegroup string
If AGE<4 then agegroup="A"
if (AGE>=4) and (AGE<7) then agegroup="B"
if (AGE>=7) and (AGE<12) then agegroup="C"
if (AGE>=12) and (AGE<18) then agegroup="D"
if (AGE>=18) and (AGE<24) then agegroup="E"
define WAZrange string
if (waz<-4) then WAZrange="A"
if (waz<-3) and (waz>=-4) then WAZrange="B"
if (waz<-2) and (waz>=-3) then WAZrange="C"
if (waz<-1) and (waz>=-2) then WAZrange="D"
if (waz<0) and (waz>=-1) then WAZrange="E"
if (waz>=0) and (waz<1) then WAZrange="F"
if (waz>=1) and (waz<2) then WAZrange="G"
if (waz>=2) and (waz<3) then WAZrange="H"
if (waz>=3) and (waz<4) then WAZrange="I"
if waz>=4 then WAZrange="J"
Define Underwt <Y>
Define Modglobal <Y>
Define Sevglobal <Y>
If WAZ<-2 then underwt = "Y" else underwt = "N"
```

```
if ((WAZ<-2.0) and (WAZ>=-3.0)) then modglobal="y" else modglobal="n"
if WAZ<-3.0 then sevglobal="y" else sevglobal="n"
if WAZ = . then modglobal = .
if waz = . then sevglobal = .
if waz = . then underwt = .
* This next line will prompt you during analysis as to where to route
* the results.
route ?Results routed to...(PRINTER, SCREEN, {Filename})?
* Gives number of children in each age group
Title 1 \lTable 1.0
Title 2 \lNumber of Children in Each Age Group
freq agegroup

* Defines a variable to generate Global Malnutrition by Age Group
define Undwtage string
if ((agegroup="A") and (Underwt="y")) then Undwtage="A"
if ((agegroup="B") and (Underwt="y")) then Undwtage="B"
if ((agegroup="C") and (Underwt="y")) then Undwtage="C"
if ((agegroup="D") and (Underwt="y")) then Undwtage="D"
if ((agegroup="E") and (Underwt="y")) then Undwtage="E"
* Prints a histogram and frequency of Underweight by Age
Title 1 \lTable 1.1
title 2 \lGlobal Malnutrition (Underweight) by Child's Age Group
freq Undwtage
* Histogram Undwtage

* Defines a variable to generate Z-scores for All 0-3 Month Olds Weighed
define WAzscor03 string
if ((WAZrange="A") and (agegroup="A")) then WAzscor03="A"
```

```
if ((WAZrange="B") and (agegroup="A")) then WAzscor03="B"
if ((WAZrange="C") and (agegroup="A")) then WAzscor03="C"
if ((WAZrange="D") and (agegroup="A")) then WAzscor03="D"
if ((WAZrange="E") and (agegroup="A")) then WAzscor03="E"
if ((WAZrange="F") and (agegroup="A")) then WAzscor03="F"
if ((WAZrange="G") and (agegroup="A")) then WAzscor03="G"
if ((WAZrange="H") and (agegroup="A")) then WAzscor03="H"
if ((WAZrange="I") and (agegroup="A")) then WAzscor03="I"
if ((WAZrange="J") and (agegroup="A")) then WAzscor03="J"
* Prints a histogram and frequency of Z-scores for All 0-3 Month Olds
Title 1 \lTable 1.2
title 2 \lZ-scores for WA by Group of All 0-3 Month Olds
freq WAzscor03
* Histogram WAzscor03
* Defines a variable to generate Z-scores for All 4-6 month olds
define WAzscor46 string
if ((WAZrange="A") and (agegroup="B")) then WAzscor46="A"
if ((WAZrange="B") and (agegroup="B")) then WAzscor46="B"
if ((WAZrange="C") and (agegroup="B")) then WAzscor46="C"
if ((WAZrange="D") and (agegroup="B")) then WAzscor46="D"
if ((WAZrange="E") and (agegroup="B")) then WAzscor46="E"
if ((WAZrange="F") and (agegroup="B")) then WAzscor46="F"
if ((WAZrange="G") and (agegroup="B")) then WAzscor46="G"
if ((WAZrange="H") and (agegroup="B")) then WAzscor46="H"
if ((WAZrange="I") and (agegroup="B")) then WAzscor46="I"
if ((WAZrange="J") and (agegroup="B")) then WAzscor46="J"
* Prints a histogram and frequency of Z-scores for All 4-6 Month Olds
Title 1 \lTable 1.3
title 2 \lZ-scores for WA by Group of All 4-6 Month Olds
```

```
freq WAzscor46
* Histogram WAzscor46
* Defines a variable to generate Z-scores for All 7-11 month olds
define WAzscor711 string
if ((WAZrange="A") and (agegroup="C")) then WAzscor711="A"
if ((WAZrange="B") and (agegroup="C")) then WAzscor711="B"
if ((WAZrange="C") and (agegroup="C")) then WAzscor711="C"
if ((WAZrange="D") and (agegroup="C")) then WAzscor711="D"
if ((WAZrange="E") and (agegroup="C")) then WAzscor711="E"
if ((WAZrange="F") and (agegroup="C")) then WAzscor711="F"
if ((WAZrange="G") and (agegroup="C")) then WAzscor711="G"
if ((WAZrange="H") and (agegroup="C")) then WAzscor711="H"
if ((WAZrange="I") and (agegroup="C")) then WAzscor711="I"
if ((WAZrange="J") and (agegroup="C")) then WAzscor711="J"
* Prints a histogram and frequency of Z-scores for All 7-11 Month Olds
Title 1 \lTable 1.4
title 2 \lZ-scores For WA by Group of All 7-11 Month Olds
freq WAzscor711
* Histogram WAzscor711
* Defines a variable to generate Z-scores for All 12-17 month olds
define WAzscor12 string
if ((WAZrange="A") and (agegroup="D")) then WAzscor12="A"
if ((WAZrange="B") and (agegroup="D")) then WAzscor12="B"
if ((WAZrange="C") and (agegroup="D")) then WAzscor12="C"
if ((WAZrange="D") and (agegroup="D")) then WAzscor12="D"
if ((WAZrange="E") and (agegroup="D")) then WAzscor12="E"
if ((WAZrange="F") and (agegroup="D")) then WAzscor12="F"
if ((WAZrange="G") and (agegroup="D")) then WAzscor12="G"
if ((WAZrange="H") and (agegroup="D")) then WAzscor12="H"
```

```
if ((WAZrange="I") and (agegroup="D")) then WAzscor12="I"
if ((WAZrange="J") and (agegroup="D")) then WAzscor12="J"
* Prints a histogram and frequency of Z-scores for All 12-17 Month Olds
Title 1 \lTable 1.5
title 2 \lZ-scores for WA by Group of All 12-17 Month Olds
freq WAzscor12
* Histogram WAzscor12
* Defines a variable to generate Z-scores for All 18-23 month olds
define WAzscor18 string
if ((WAZrange="A") and (agegroup="E")) then WAzscor18="A"
if ((WAZrange="B") and (agegroup="E")) then WAzscor18="B"
if ((WAZrange="C") and (agegroup="E")) then WAzscor18="C"
if ((WAZrange="D") and (agegroup="E")) then WAzscor18="D"
if ((WAZrange="E") and (agegroup="E")) then WAzscor18="E"
if ((WAZrange="F") and (agegroup="E")) then WAzscor18="F"
if ((WAZrange="G") and (agegroup="E")) then WAzscor18="G"
if ((WAZrange="H") and (agegroup="E")) then WAzscor18="H"
if ((WAZrange="I") and (agegroup="E")) then WAzscor18="I"
if ((WAZrange="J") and (agegroup="E")) then WAzscor18="J"
* Prints a histogram and frequency of Z-scores for All 18-23 Month Olds
Title 1 \lTable 1.6
title 2 \lZ-scores for WA by Group of All 18-23 Month Olds
title 3
freq WAzscor18
* Histogram WAzscor18
* THIS NEXT TABLE IS EXTREMELY IMPORTANT
* Runs a frequency for malnutrition among All children weighed
Title 1 \lTable 2.1
title 2 \lPercentage of All Children Weighed
```

```
Title 3 \lWho Had Global Malnutrition (Underweight, WAZ<-2)
freq Underwt
Title 1 \lTable 2.2
title 2 \lPercentage of All Children Weighed
Title 3 \lWho Were Moderately Underweight (-2 > WAZ >= -3)
Freq modglobal
Title 1 \lTable 2.3
title 2 \lPercentage of All Children Weighed
Title 3 \lWho Were Severely Underweight (WAZ<-3)
Freq sevglobal

* This next line will prompt you during analysis as to where to route
* the results for the mean WA Z-score.  (It's best to route this to a file!)
route ?WA means routed to...(PRINTER, SCREEN, {Filename})?
* THIS NEXT SECTION GENERATES A MEAN (AVERAGE) Z-SCORE FOR EACH AGE GROUP.
Title 1 \lTable 3.1
Title 2 \lMean Z-score for WA for 0-3 Month Olds
Title 3 \l
select AGE <4
DESCRIBE WAZ
select
* Removes outliers (per Epi-Info criteria)
Select WAZ < 6
Select WAZ > -6

Title 1 \lTable 3.2
Title 2 \lMean Z-score for WA for 4-6 Month Olds
select AGE>=4
Select AGE<7
```

```
DESCRIBE WAZ
select

* Removes outliers (per Epi-Info criteria)
Select WAZ < 6
Select WAZ > -6

Title 1 \lTable 3.4
Title 2 \lMean Z-score for WA for 7-11 Month Olds
select AGE>=7
select AGE<12
DESCRIBE WAZ
Select

* Removes outliers (per Epi-Info criteria)
Select WAZ < 6
Select WAZ > -6

Title 1 \lTable 3.5
Title 2 \lMean Z-score for WA for 12-17 Month Olds
Select AGE>=12
Select AGE<18
DESCRIBE WAZ
Select
* Removes outliers (per Epi-Info criteria)
Select WAZ < 6
Select WAZ > -6

Title 1 \lTable 3.6
```

```
Title 2 \lMean Z-score for WA for 18-23 Month Olds

select AGE>=18

select AGE<24

DESCRIBE WAZ

Select

* Removes outliers (per Epi-Info criteria)

Select WAZ < 6

Select WAZ > -6


route ?Final Digit data routed to...(PRINTER, SCREEN, {Filename})?

Title 1 Final Digits of Weights (Check for Rounding)

Define FINALDIGIT #

FINALDIGIT = FRAC(WEIGHT)*10

If WEIGHT = . then Finaldigit = .

FINALDIGIT = FINALDIGIT * 10

FINALDIGIT = FINALDIGIT / 10

Freq FINALDIGIT

Select
```

D. ENGLISH QUESTIONNAIRES

Mozambique Expanded Impact Child Survival Project

Knowledge, Practices, and Coverage (KPC) Survey Questionnaire for

0-11 month old children ONLY

Revised for FINAL EVALUATION

April 30th 2010

Carolyn Wetzel, MPH&TM

Emma Hernandez Avilan, RN

Tom Davis, MPH

INTERVIEWER INSTRUCTIONS:

A. CHOOSE THE STARTING HOUSEHOLD AND ASK ABOUT CHILDREN UNDER TWO. IF YOU FIND NEITHER, THEN GO TO THE NEXT NEAREST HOUSEHOLD.

- IF YOU FIND ONE INFANT (0-11M OLD), THEN INTERVIEW THAT MOTHER AND GO TO THE NEXT NEAREST HOUSE, NEXT NEAREST, ETC. UNTIL YOU FIND A 12-23M OLD. IF YOU FIND A 12-23M OLD FIRST, THEN INTERVIEW THAT MOTHER, THEN GO TO THE NEXT NEAREST HOUSE, NEXT NEAREST, ETC., UNTIL YOU FIND AN INFANT.

- IF YOU FIND *BOTH* AN INFANT AND 12-23M IN A HOUSEHOLD (AND YOU HAVE NOT INTERVIEWED ANY MOTHERS AT THAT SITE), YOU CHOOSE ONE OF THE TWO *AT RANDOM*, INTERVIEW THE MOTHER OF THAT CHILD, THEN GO TO THE NEXT NEAREST HOUSE TO FIND THE MISSING CHILD (i.e., THE CHILD IN THE OTHER AGE GROUP).

- IF YOU FIND SEVERAL CHILDREN IN THE AGE GROUPS (e.g., ONE INFANT AND TWO 12-23M OLDS) AT ONE HOUSEHOLD THEN CHOOSE ONE OF THEM AT RANDOM (VERY IMPORTANT!), THEN GO LOOKING FOR THE MISSING ONE AT A DIFFERENT HOUSEHOLD.

- **ONE IMPORTANT THING** – DO NOT TAKE THE MOTHER OF THE INFANT AND THE MOTHER OF THE 12-23M OLD FROM THE SAME HOUSE. THEY SHOULD BE TWO MOTHERS WHO LIVE IN DIFFERENT HOUSEHOLDS.

B. **Selection of Respondent:** At the first house chosen for the interview, ask an adult in the household if there are any children who live in the house who are under two years of age. If so, ask for their names and ages. Select one of those children at random, and ask to speak to the mother, or chief caregiver of that child. (If you do not pick one AT RANDOM, it introduces selection bias, and we would have to REPEAT THE ENTIRE STUDY.) CHOOSE THE CORRECT QUESTION-NAIRE TO USE BASED ON THE CHILD'S AGE. This questionnaire is for children 0-11m of age only. Verify that the child is the age that you were originally told (under 24 months) and begin the consent process below. If no child under two is found in the household, proceed to the next nearest house (next nearest door) until a child under 24 months of age is found, and repeat the process above

C. **We want to interview the biological mother if at all possible**. Only interview someone other than the biological mother of the child if the biological mother (1) has died OR (2) has been absent from the child for more than 6 months, OR (3) has give the child to someone else to care for on a regular basis (e.g. because she cannot care the child). (You should SKIP the breastfeeding questions if the main child care provider is not the mother.) If the biological mother normally cares of the child, but she is more than 30 minutes away, choose another child for the interview. Keep track of how many mothers were not at home, and inform your supervisor.

D. **Child's age:** when recoding the child's age in months (**Q. # 9**), be sure to ***ROUND DOWN*** . If this child is 2 months and 30 days, the child is still 2 months. If the child was born on June 15th and today is August 14th the child is still only 2 months old. If the child was born on June 15th and today is June 14th the child is not yet one month old. Please record ZERO for the age in months. Do not record age in weeks – i.e. Two weeks – only in months. If a child is less than one full month of age, record ZERO as the age.

INFORMED CONSENT

Before interviewing a mother or chief caregiver, you must get her/his consent to conduct the interview. Please read the informed consent exactly as it is written. This statement explains the purpose of the survey and the voluntary nature of the respondent's participation, then seeks her/his cooperation. After reading the statement, you (not the respondent) must sign the space provided to affirm that you have read the statement to the mother/chief caregiver. Circle "1" if the mother/chief caregiver agrees to be interviewed and proceed to the modules. If the mother/chief caregiver does not agree to be interviewed, circle "2", thank her/him for her/his time, and end the interview.

INFORMED CONSENT STATEMENT

Hello. My name is _____, and I am working with Food for the Hungry. We are conducting a survey and would appreciate your participation. I would like to ask you about your health and the health of one of your children. This information will help (Food for the Hungry) to assess whether it is meeting its goals to improve children's health. The survey usually takes _____ minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the survey? ***[Answer any questions the mother/chief caregiver has.]***

Do you agree to be interviewed?

RESPONDENT AGREES TO BE INTERVIEWED . . . . . 1 → **DO INTERVIEW**

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED…2 → **END INTERVIEW**

Signature of interviewer: _____

Date: _____ / _____ / _____
dd mm yyyy

Questionnaire Number _____

Interviewer's Name: _____

Supervisor's Name:_____ HH No.: _____

Interview Date:__/___/____ Community: _____

dd mm yyyy

District: _____ Supervision area #: ____

For this questionnaire, all questions to be asked of <u>Mothers</u> or <u>chief care providers</u> of children <u>less than 12 months</u> of age

I. RESPONDENT INFORMATION:

1. Does the mother of this child live with the child? 1. Yes 2. No	***(SPEAK TO THE PRIMARY CARE PROVIDER OF THE CHILD)*** **2. What is your relationship to this child? [IF mother – prompt biological or adoptive]** 1. Biological Mother 2. Adoptive Mother 3. Biological Father 4. Adoptive Father 5. Grandmother 6. Aunt 7. Other (Specify: _____)
3. *(Ask respondent:)* How old are you? _____ years	**4. GENDER OF <u>RESPONDENT</u>:** ❑ Female ❑ Male

NO.	QUESTIONS

5. How many children living in this household are under five years of age?

1. ONE CHILD
2. TWO CHILDREN
3. THREE OR MORE CHILDREN
4. DON'T KNOW/NO REPONSE

6. How many of those children are your biological children?

1. ONE CHILD
2. TWO CHILDREN
3. THREE OR MORE CHILDREN
9. DON'T KNOW/NO RESPONSE

7. What are the, names, sex and date of birth of your two youngest children?

	NAME	SEX	DATE OF BIRTH
1		1. MALE 2. FEMALE	__ __ / __ __ / _____ dd mm yyyy
2		1. MALE 2. FEMALE	__ __ / __ __ / _____ dd mm yyyy

ALL SUBSEQUENT QUESTIONS PERTAIN TO THE CHILD SELECTED WHO IS UNDER AGE TWO WHEN USING "(NAME)"

***INTERVIEWER**: Explain that you would **later** like to check information on the child's "clinic card" (immunization card/growth monitoring card) and ask her to get them **now** if she has them. The child's clinic card may also have the birth date on it.*

NO.	QUESTIONS

8. What is (NAMES's) date of birth? ***[CONFIRM WITH GM OR IMMUNIZATION CARD]***

____ / ____ / _____ ❑ Don't know

dd mm yyyy

9. How is old is (NAME)? _____ months ❑ Don't know

[NOTE – If the child is <u>12-23m of age</u>, USE OTHER QUESTIONNAIRE!]

9.a Is (NAME) male or female?

1. MALE

NO.	QUESTIONS

2. FEMALE

9. DON'T KNOW / NO RESPONSE

10. For how many years have you attended school? _____ years

[IF NEVER RECORD '00'; IF DON'T KNOW, LEAVE BLANK]

11. Who takes care of (NAME) when you are <u>away from home</u>? (If no one else, mark "4" below. If someone else besides mother, ASK:) Did this person hear the Leader Mother's lessons when she did a home visit or group meeting in the past month?

1. **YES, THIS PERSON HEARD LEADER MOTHER LESSON IN LAST MONTH**
2. **NO, THIS PERSON DID NOT HEAR LM LESSON IN LAST MONTH**
3. **DON'T KNOW**
4. **NO OTHER PERSON TAKES CARE OF CHILD**
5. **LM DID NOT DO A HOME VISIT OR GROUP MEETING IN THE LAST MONTH.**

II. WATER AND SANITATION

NO.	QUESTIONS

12. Now I would like to ask you some questions about your household.

What is the <u>main</u> source of drinking water for members of your household?

1. PIPED INTO DWELLING / YARD / PLOT
2. PUBLIC TAP
3. OPEN WELL IN DWELLING / YARD / PLOT
4. OPEN PUBLIC WELL
5. PROTECTED WELL IN DWELLING / YARD / PLOT
6. PROTECTED PUBLIC WELL
7. SPRING / RIVER / STREAM
8. POND / LAKE / DAM
9. RAINWATER
10. OTHER (SPECIFY)_____
99. DON'T KNOW / NO RESPONSE

13. In the past week, did you do anything to the water given to (NAME) to make it safer to drink? If so, what? (What else?) ***[MULTIPLE ANSWERS ALLOWED]***

A. DID NOTHING / DID NOT TREAT THE WATER
B. BOILED THE WATER
C. ADDED BLEACH / CHLORINE TO THE WATER
D. USED A COMMERCIAL WATER PURIFICATION PRODUCT (e.g., PUR)
E. SIEVED IT THROUGH A FINE CLOTH
F. USED A WATER FILTER (ceramic, sand, composite)
G. USED SOLAR DISINFECTION (left it in the sun)
H. USED SEDIMENTATION (left it so sediment falls to the bottom)
X. OTHER (Please specify:) _____

14. The last time (NAME) passed stool, where did he/she defecate?

1. USED A LATRINE, TOILET, OR IN A SPECIALLY DUG HOLE IN THE GROUND
2. USED POTTY (INDOOR POT OR PAN)
3. USED WASHABLE DIAPERS
4. USED DISPOSABLE DIAPERS
5. WENT ON FLOOR IN HOUSE
6. WENT OUTSIDE OF HOUSE ON THE GROUND (BUT NOT IN A DUG HOLE)
7. WENT IN HIS / HER CLOTHS
8. OTHER (SPECIFY): _____
9. DON'T KNOW

15. Does your household have a special place for hand washing?

1. YES
2. NO→**skip to Q. #23**
9. DON'T KNOW/NO RESPONSE→**skip to Q. #23**

16. *ASK TO SEE THE PLACE USED MOST OFTEN FOR HAND WASHING AND <u>OBSERVE</u> IF THE FOLLOWING ITEMS ARE PRESENT:*

	YES	NO
(A) WATER/TAP	1	2
(B) SOAP, ASH OR OTHER CLEASING AGENT	1	2
(C) BASIN	1	2

---

17. When do you wash your hands with soap/ash? (When else?) *[MULTIPLE ANSWERS ALLOWED]*

A. DON'T KNOW/NO RESPONSE
B. NEVER
C. BEFORE FOOD PREPERATION
D. BEFORE FEEDING CHILDREN
E. AFTER DEFECATION
F. AFTER ATTENDING TO A CHILD WHO HAS DEFECATED
X. OTHER (SPECIFY)_____

III. MATERNAL AND NEWBORN CARE

NO.	QUESTIONS
	[IF RESPONDENT IS NOT THE BIOLOGICAL MOTHER OF (NAME), SKIP TO QUESTION #30]

Formatted: No bullets or numbering

18. **Before you gave birth to (NAME) did you receive an injection in the arm to prevent the baby from getting tetanus, that is, convulsions after birth?**

1. YES
2. NO→**skip to Q. #26**
9. DON'T KNOW/NO RESPONSE→**skip to Q. #26**

19. **How many times did you receive such an injection?**

1. ONCE
2. TWICE
3. MORE THAN TWO TIMES
9. DON'T KNOW/NO RESPONSE

19b. **When you gave birth to (NAME), did a Leader Mother or health worker visit you in your home <u>during the FIRST WEEK</u> after you delivered?**

1. **YES**
2. **NO**
3. **DON'T KNOW**

NO.	QUESTIONS

20. Now I would like to ask you about the time when you gave birth to (NAME). Who assisted you with (NAME'S) delivery? (Who else?) ***[MULTIPLE ANSWERS ALLOWED]***

A. DON'KNOW/CAN'T REMEMBER/NO RESPONSE
B. DOCTOR
C. NURSE/MIDWIFE
D. AUXILIARY MIDWIFE
E. TRADITIONAL BIRTH ATTENDANT
F. COMMUNITY HEALTH WORKER
G. FAMILY MEMBER _____
(SPECIFY RELATIONSHIP TO RESPONDENT)
H. NO ONE
I. LEADER MOTHER
X. OTHER (SPECIFY:) _____

21. When you were pregnant with (NAME), for how many months did you take iron supplements? ***[SHOW TABLETS]***

[IF NEVER OR LESS THAN 15 DAYS RECORD '00'. IF RESPONDENT MENTIONS DAYS, CONVERT TO DAYS BY DIVIDING BY 30.]

_____ MONTHS

99. Don't know / No response

22. During your pregnancy with (Name), for how many months did you receive antenatal care?
____ months ❑ Don't know

IV. BREASTFEEDING AND INFANT/CHILD NUTRITION

NO.	QUESTIONS
	[IF RESPONDENT IS NOT BIOLOGICAL MOTHER OF (NAME), SKIP TO Q#35]

23. Did you ever breastfeed (NAME)?

1. YES
2. NO→**skip to Q. #35**
9. DON'T KNOW/NO RESPONSE→**skip to Q. #35**

24. How long after birth did you first put (NAME) to the breast?

1. IMMEDIATELY/WITHIN FIRST HOUR AFTER BIRTH
2. BETWEEN 1 AND 8 HOURS

3. AFTER THE FIRST EIGHT HOURS
9. DON'T REMEMBER/DON'T KNOW

25. During the first three days after delivery, did you give (NAME) the liquid that came from your breasts?

1. YES
2. NO
9. DON'T KNOW/NO RESPONSE

26. During the first three days after delivery, did you give (NAME) anything else to <u>eat or drink</u> before feeding him/her breast milk?

1. YES
2. NO → **skip to Q. #33**
9. DON'T KNOW/NO RESPONSE

27. During the first three days after delivery, what did you give (NAME) to eat or drink?

[DO NOT READ THE LIST. MARK ALL THAT THE MOTHER MENTIONS. PROMPT WITH "Anything else?" AFTER EACH RESPONSE]

*[**MULTIPLE RESPONSES ALLOWED]***

A. DON'T KNOW/NO RESPONSE
B. MILK (OTHER THAN BREASTMILK)
C. PLAIN WATER
D. WATER WITH SUGAR AND/OR SALT
E. FRUIT JUICE
F. TEA/INFUSIONS
G. LIQUID OR SEMI-LIQUID TRADITIONAL MEDICINE
H. INFANT FORMULA
X. OTHER (SPECIFY)_____

28. Are you currently breastfeeding (NAME)?

1. YES → **skip to #35**
2. NO
9. DON'T KNOW/NO RESPONSE

NO.	QUESTIONS

29. For how long did you breastfeed (NAME)?

[IF LESS THAN ONE MONTH, RECORD "00" MONTHS]

___ ____ MONTHS

❑ DON'T KNOW/NO RESPONSE

30. Now I would like to ask you about the types of liquids (NAME) drank yesterday during the day and at night. Did (NAME) drink any of the following liquids yesterday during the day or at night?

[READ THE LIST OF LIQUIDS (B THROUGH H, STARTING WITH "BREASTMILK"). CIRCLE THE LETTER IF THE CHILD DRANK THE LIQUID IN QUESTION -- MULTIPLE RESPONSES ALLOWED. PROMPT WITH, "Anything else?" AFTER EACH RESPONSE.]

A. Breastmilk?
B. Plain water?
C. Commercially produced infant formula?
D. Any other milk aside from breastmilk such as powdered milk, tinned milk or fresh animal milk?
E. Fruit juice?
F. Tea or coffee?
G. Traditional medicines that were liquid or semi-liquid?
H. Maheu
I. **Any other liquids?** (SPECIFY:) _____
J. RESPONDENT DOES NOT MENTION ANY LIQUIDS / NO RESPONSES GIVEN

NO.	QUESTIONS

31. I would like to ask you about the food (NAME) ate yesterday during the day and at night, either separately or combined with other foods. Did (NAME) eat any of the following foods yesterday during the day or at night? Anything else?

[READ THE LIST OF FOODS. CIRCLE THE LETTER IF CHILD ATE THE FOOD IN QUESTION -- MULTIPLE RESPONSES ALLOWED]

- **A. Any porridge of gruel?**
- **B. Any baby food sold in a can or bottle?**
- **C. Any bread, rice, noodles, biscuits, cookies, or ay other food made from grains?**
- **D. Any white potatoes, white yams, manioc, cassava, or any other foods made from roots?**
- **E. Any pumpkin, carrots, squash or sweet potatoes that are yellow or orange inside?**
- **F. Any dark green leafy vegetables?**
- **G. Any ripe mangoes, papayas (or other local vitamin A-rich fruits?)**
- **H. Any other fruits or vegetables?**
- **I. Any liver, kidney, heart, or other organ meats?**
- **J. Any beef, pork, lamb, goat, rabbit , or other RED meat obtained through hunting?**
- **K. Any chicken, duck, or other birds (including those that are hunted)?**
- **L. Any eggs?**
- **M. Any fresh or dried fish or shellfish?**
- **N. Any foods made from beans, peas, or lentils?**
- **O. Any nuts?**
- **P. Any cheese or yogurt?**
- **Q. Any food made with other oil, fat or butter?**
- **R. Any other solid or semi-solid food?**
- **S.** RESPONDENT DID NOT MENTION ANY FOODS / NO RESPONSES GIVEN

32. Did (NAME) drink anything from a bottle with a nipple yesterday or last night?

1. YES
2. NO
9. DON'T KNOW/NO RESPONSE

33. How many times did (NAME) eat solid, semi-solid, or soft foods other than liquids yesterday during the day and at night? (What type of food did he/she eat?)

NOTE!:

- ***WE WANT TO FIND OUT HOW MANY TIMES THE CHILD ATE ENOUGH TO BE FULL.***
- ***SMALL SNACKS AND SMALL FEEDS SUCH AS ONE OR TWO BITES OF MOTHER'S OR SISTER'S FOOD SHOULD <u>NOT</u> BE COUNTED.***
- ***LIQUIDS DO <u>NOT</u> COUNT FOR THIS QUESTION.***
- ***DO <u>NOT</u> INCLUDE THIN SOUPS OR BROTH, WATERY GRUELS, OR ANY OTHER LIQUID.***

[USE PROBING QUESTIONS TO HELP THE RESPONDENT REMEMBER ALL THE TIMES THE CHILD ATE YESTERDAY]

__ ___ NUMBER OF TIMES CHILD ATE

❑ DON'T KNOW/NO RESPONSE

NO.	QUESTIONS

34. When you made food for (NAME) yesterday, did you add oil to (NAME's) food?

1. YES
2. NO
3. DID NOT MAKE FOOD FOR CHILD YESTERDAY
9. DON'T KNOW/NO RESPONSE

35. Did (NAME) receive a vitamin A supplement like this during the last 6 months?

[SHOW AMPULE/CAPSULE/SYRUP]

1. YES
2. NO
9. DON'T KNOW / NO RESPONSE

V. DIARRHEA

NO.	QUESTIONS

36. Has (NAME) had diarrhea in the last 2 weeks?

1. YES
2. NO →**skip to Q. #49**

9. DON'T KNOW/NO RESPONSE

37. What was given to treat the diarrhea or to prevent dehydration? (Anything else?)

[MULTIPLE RESPONSES ALLOWED]

A. DON'T KNOW/NO RESPONSE
B. NOTHING
C. PILL OR SYRUP (OTHER THAN ZINC)
D. INJECTIONS
E. IV (INTRAVENOUS) FLUIDS
F. HOME REMEMDIES/HERBAL MEDICINES (given in small amounts of liquid)
G. FLUID FROM THE ORS PACKETS
H. RECOMMENDED HOME FLUIDS (e.g., water, juice)
I. ZINC TABLETS
X. OTHER (SPECIFY)_____

NO.	QUESTIONS

38. When (NAME) had diarrhea, did you breastfeed him/her less than usual, about the same amount, or more than usual?

1. LESS
2. SAME
3. MORE
4. STOPPED BREASTFEEDING COMPLETELY
5. CHILD NOT BREASTFED AT TIME OF DIARRHEA

39. When (NAME) had diarrhea, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?

1. OFFERED LESS
2. OFFERED SAME
3. OFFERED MORE
4. NOT OFFERED ANYTHING TO DRINK (i.e., stopped giving liquids completely)
9. DON'T KNOW/NO RESPONSE

40. When (NAME) had diarrhea, was he/she offered less than usual to eat, about the same amount, or more than usual to eat?

1. OFFERED LESS
2. OFFERED SAME
3. OFFERED MORE
4. NOT OFFERED ANYTHING TO EAT (i.e., stopped giving solid foods completely)
9. DON'T KNOW/NO RESPONSE

41. During the weeks after (NAME) has had diarrhea, after the diarrhea has stopped, do you generally give him/her less than usual to eat, about the same amount, or more than usual to eat?

1. OFFERED LESS
2. OFFERED SAME
3. OFFERED MORE
4. NEVER HAD DIARRHEA
9. DON'T KNOW / NO RESPONSE

NO.	QUESTIONS

42. Have you heard of ORS?

- ***IF <u>YES</u>, ASK MOTHER/CHIEF CARE PROVIDER TO DESCRIBE ORS PREPARATION FOR YOU.***
- ***IF <u>NO</u>, CIRCLE REPONSE 4 (NEVER HEARD OF ORS).***

[ONCE MOTHER/CHIEF CARE PROVIDER HAS PROVIDED A DESCRIPTION, RECORD WHETHER S/HE DESCRIBED ORS PREPARATION CORRECTLY OR INCORRECTLY.]

CIRCLE 1 [CORRECTLY] IF THE MOTHER/CHIEF CARE PROVIDER MENTIONED THE FOLLOWING:

- USE <u>1 LITER</u> OF CLEAN DRINKING WATER (1 LITER=3 SODA BOTTLES)
- USE THE <u>ENTIRE</u> PACKET
- <u>DISSOLVE</u> THE POWDER FULLY

1. DESCRIBED CORRECTLY
2. DESCRIBED INCORRECTLY
3. HEARD OF ORS BUT MOTHER REFUSES TO DESCRIBE PROCESS
4. NEVER HEARD OF ORS

VI. IMMUNIZATIONS

(Questions on immunizations are integrated in below.)

VII. CHILDHOOD ILLNESSES

NO.	QUESTIONS
43.	**Sometimes children get sick and need to receive care or treatment for illnesses. What are the signs of illness that would indicate your child needs treatment? (Any other signs?)** ***[MULTIPLE RESPONSES ALLOWED]*** A. DON'T KNOW/NO RESPONSE B. LOOKS UNWELL OR NOT PLAYING NORMALLY C. NOT EATING OR DRINKING

NO.	QUESTIONS
	D. LETHARGIC OR DIFFICULT TO WAKE E. HIGH FEVER F. FAST OR DIFFICULT BREATHING G. VOMITS EVERYTHING H. CONVULSIONS I. OTHER (SPECIFY)_____ J. OTHER (SPECIFY)_____ K. OTHER (SPECIFY)_____

VIII. ADDITIONAL RAPID CATCH QUESTIONS

NO.	QUESTIONS
44.	**Do you have any bed nets in your house?** 1. YES 2. NO → **skip to Q. #58** 8. DON'T KNOW → **skip to Q. #58**
45.	**Who slept under a bed net last night? (Who else?) [*MULTIPLE RESPONSES ALLOWED.]*** A. CHILD (NAME) B. RESPONDENT C. OTHER INDIVIDUAL(S) _____ (SPECIFY)
46.	**Was the bed net ever soaked or dipped in a liquid to repel mosquitoes or bugs?** 1. YES 2. NO 9. DON'T KNOW
47.	**What can a person do to avoid getting AIDS or the virus that causes AIDS? (What else?)** ***[MULTIPLE RESPONSES ALLOWED]*** A. NOTHING B. ABSTAIN FROM SEX C. USE CONDOMS

NO.	QUESTIONS
	D. LIMIT SEX TO ONE PARTNER/STAY FAITHFUL TO ONE PARTNER E. LIMIT NUMBER OF SEXUAL PARTNERS F. AVOID SEX WITH PROSTITUTES G. AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS H. AVOID INTERCOURSE WITH PERSONS OF THE SAME SEX ***(NOTE: RESPONSES CONTINUED ON NEXT PAGE)*** I. AVOID SEX WITH PERSONS WHO INJECT DRUGS INTRAVENOUSLY J. AVOID BLOOD TRANSFUSIONS K. AVOID INJECTIONS L. AVOID KISSING M. AVOID MOSQUITO BITES N. SEEK PROTECTION FROM TRADITIONAL HEALER O. AVOID SHARING RAZORS, BLADES P. OTHER_____ (SPECIFY) _____ Q. OTHER_____ (SPECIFY) _____ R. NEVER HEARD OF AIDS S. DON'T KNOW

IX. GROWTH MONITORING AND CHILD ANTHTROPOMETRY

NO.	QUESTIONS
48.	**Was (NAME) have a growth monitoring card?** IF YES: **May I see it please?** 1. YES, SEEN 2. NOT AVAILABLE / CARD MISPLACED → **skip to Q. #51** 3. NEVER HAD A CARD → **skip to Q. #51** 9. DON'T KNOW/NO RESPONSE → **skip to Q. #51**
49.	**LOOK AT (NAME) GROWTH MONITROING CARD AND SEE IF (NAME) WAS WEIGHED IN THE <u>FIRST TWO MONTHS OF LIFE</u>** 1. YES 2. NO 9. CANNOT DETERMINE FOR SURE

NO.	QUESTIONS
50.	**LOOK AT (NAME) GROWTH MONITORING CARD AND SEE IF (NAME) HAS BEEN WEIGHED <u>IN THE LASTS FOUR MONTHS</u>** 1. YES 2. NO 9. CANNOT DETERMINE FOR SURE
51.	**[Skipped]**

X. OTHER KPC QUESTIONS BASED ON MINI-KPCs

52. **After you gave birth to (NAME) did you receive a dose of vitamin A (by swallowing a yellow capsule or by receiving drops on your tongue)?**

1. YES
2. NO→**skip to Q. #54**
9. DON'T KNOW/NO RESPONSE→**skip to Q. #54**

53. **How soon after you gave birth to (NAME) were you given the dose of vitamin A?**

1. Before (NAME) was two months old
2. After (NAME) was two months old
3. Mother never received vitamin A
4. Don't Know/No Response

54. **What are the signs of danger after giving birth indicating the need for you to seek health care? *[MULTIPLE ANSWERS ALLOWED]***

A. FEVER

B. EXCESSIVE BLEEDING

C. SMELLY VAGINAL DISCHARGE

D. DON'T KNOW/NO RESPONSE

X. OTHER (SPECIFY)_____

55. **When breastfeeding (NAME) do you offer both breasts at each feed?**

1. YES
2. NO→**skip to Q. 57**
9. DON'T KNOW/NO RESPONSE→**skip to Q. #57**

56. **When breastfeeding (NAME) do you usually completely empty both breasts?**

1. YES
2. NO
9. DON'T KNOW/NO RESPONSE

57. **How do you keep food after you prepare it?**

1. MENTIONS COVERING IT OR REFRIGERATING IT
2. DOES NOT MENTION COVERING IT OR REFRIGERATING IT
9. DON'T KNOW/NO RESPONSE

58. **During the past two weeks, have you received a visit from a Leader Mother?**

1. YES
2. NO
3. RESPONDENT IS A LEADER MOTHER
9. DON'T KNOW/NO RESPONSE

59. **How soon after a child is born should the mother start to breastfeed? Quanto tempo depois do parto uma mãe deve por sua criança à mamar?**

1. IMEDIATAMENTE/DENTRO DA PRIMEIRA HORA APÓS O PARTO
2. DEPOIS DA PRIEIRA HORA APÓS O PARTO
9. NÃO SABE / NÃO RESPONDEU

60. **In your opinion, does breastfeeding while you are pregnant endanger your child in anyway? Na sua opiniao, voce esta a perjudicar a sua crianca de alguma maneira se a amamenta duante uma nova gravidez ?**

1. SIM
2. NÃO
9. NÃO SABE/NÃO RESPONDE

61. **Do you believe that men have more value than women, that women have more value than men, or that they are equal? (Voce acredita que vale mais a homen que a mulher, vale mais a mulher que a homen, o sao iguais ?)**

1. Homen vale mais
2. Mulher vale mais
3. Sao Iguais
9. NÃO SABE / NÃO RESPONDEU

62. **If a mother knows that she is HIV+, how should she feed her child for the first six months? (Se por acaso uma mãe tem conhecimento que e HIV+, como iria alimentar a sua criança ate atingir os seis meses de idade ?)**

1. DA SO LEITE MATERNA , SIM OUTORS LIQUIDOS O COMIDA
2. DA LEITE MATERNA E OUTRAS COMIDAS OU LIQUIDOS
3. OUTRA RESPOSTA (INCORRECTA). QUAL? _____
9. NÃO SABE/NÃO RESPONDEU

63. **How can a woman prevent anemia during pregnancy? (MULTIPLE REPSONSES POSSIBLE) (Como pode a mulher prevenir a anemia durante a gravidez? [SÃO PERMITIDAS MÚLTIPLAS RESPOSTAS])**

1. Eat food rich in iron, such as red meat, bird meat, and green leaves (Comer comidas ricas em ferro como carnes, aves, e folhas verdes)
2. Eat iodized salt (Comer Sal idoado)
3. Take supplements of iron and folic acid (Tomar suplementos com ferro e acido folico)
4. Sleep under a mosquito net (Dormir embaixo da rede mosquiteira)
9. DON'T KNOW / NO RESPONSE (NÃO SABE/NÃO RESPONDEU)

---

64. **Did you child have a fever in the last two weeks? A sua criança teve Febres nas ultimas duas semanas?**

1. Sim
2. Nao → **Saltar para a Pergunta #67**
9. Nao Sabe/ Nenhuma Resposta

---

65. **Did you seek advice or treatment when your child had a fever? Você procurou aconselhamento ou tratamento quando a criança teve febre?**

1. Sim
2. Nao → **Saltar para a Pergunta #67**
9. Nao Sabe/ Nenhuma Resposta

---

66. **Who or where did you seek help when your child had a fever in the last two weeks? [Multiple answers allowed] De quem/onde voçê procurou ajuda quando a sua criança teve febre na ultimas duas semanas? [assinale todas respostas dadas]**

A. Traditional Healer / witchdoctor (Curandeiro Tradicional)

B. Government Hospital (Hospital do Governo)

C. Health Post (Unidade Sanitaria)

D. Religious Leader (Lideres Religiosos)

E. Private doctor or nurse (Médico/Enfremeiro Privado)

F. Pharmacy (Farmácias)

G. Lead Mother trained in C-IMCI (Mae ACS)

H. Leader Mother NOT trained in IMCI

I. Traditional Birth attendant (Parteira Tradicional)

I. Parents or friends (Parentes, amigos (pessoas de fora))

K. Nao Sabe/ Nenhuma Resposta

67. **What causes Malaria? (O que provoca a Malaria?)**

A. The bite from a mosquito /Pela picada de um mosquito

B. Withcraft /Feitiçaria

C. The use of interavenous drugs /Uso de drogas intravenosas

(NOTE: RESPONSES CATEGORIES CONTINUED ON NEXT PAGE.)

D. Blood transfusions/Transfusões de sangue

E. Injections /Injeções

F. Sharing razors/ Partilha de laminas

G. Cough /Pela tosse

H. Outro _____ (Especifique)

I. Nao Sabe/ Nenhuma Resposta

68. **Check the Card:**

How many DPT doses does (NAME) have? Has (NAME) recevied measles vaccine?

____ doses of DPT vaccine registradas no seu cartão

____ doses of Measles vaccine registradas no seu cartão

❑ Falta cartao

XI. HEALTH CONTACTS AND SOURCES OF HEALTH INFORMATION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES		
69.	**During the last month, how often have you come in contact with each of the following:**	FREQUENTLY (4 or more times)	SOMETIMES (1-3 times)	NEVER (0 times)
	Doctor	1	2	3
	Nurse/Midwife	1	2	3
	Leader Mother / Health Educator /CHW	1	2	3

	Trained Birth Attendant	1	2	3
	Traditional Healer	1	2	3

70.	**From where do you get general information or advice on health or nutrition?**	**Formal Network**	
	RECORD ALL MENTIONED.	Doctor	A
		Nurse/Midwife	B
		Leader Mother / Health Educator / CHW	C
		Trained Birth Attendant	D
		Informal Network	
		Husband/Partner	E
		Mother/Mother-In-Law	F
		Sister	G
		Grandparent	H
		Aunt	I
		Friend/Neighbor	J
		Traditional Healer	K
		Village Elder	L
		OTHER _____ (Specify)	X

71. **In the past month, have you received any health messages from any of the following sources?** ***(READ ALL RESPONSES AND CIRCLE ALL THAT ARE YES)***

A. Radio?
B. Newspaper?
C. Television?
D. Leader Mother?
E. Other Health Educator or CHW?

72. May I weigh (NAME)?

[ALSO ASK TO WEIGH ANY CHILDREN IN THE SAME HOUSEHOLD THAT ARE ALSO UNDER 12 MONTHS OF AGE.]

1. YES → **Proceed to #73 and weigh child**
2. NO → **END INTERVIEW**

ANTHROPOMETRY

Record weights of all children 0-11 months in (NAME'S) household. If there are less than three children 0-11 months of age in the household, go to the next nearest household from the front entrance of (NAME'S) house and check to see if that household contains any children 0-11 months of age. If there are children 0-11m of age there, ask the mother's/chief care providers consent, and weigh the children 0-11m of age in that house. Continue going to the next nearest household from the front entrance of the last house visited until a total of <u>three children</u> 0-11m of age have been weighed. (Then conduct the interview of a mother/chief care provider of a child 12-23m of age. The mother/chief care provider of the child 12-23m of age should NOT be the same mother/chief care provider as the mother/chief care provider of the child 0-11m of age that you interviewed.)

73. NAME OF CHILD (WEIGH [NAME] FIRST THEN WEIGH OTHER CHILDREN IN THE HOUSEHOLD WHO ARE UNDER 12 MONTHS OF AGE	**GENDER**	**What is his/her date of birth?** COPY DATEOF BIRTH FROM G/M CARD IF IT IS AVAILBALE. IF G/M CARD IS NOT AVAILABLE RECORD DATE OF BIRTH PROVIDED BY MOTHER.	**WEIGHT (KG)**
1. NAME OF CHILD IN <u>FIRST</u> HOUSEHOLD (WHERE INTERVIEW OF 0-11m OLD WAS CONDUCTED):	❑ Male ❑ Female	_____ / _____ / _____ dd mm yyyy	**_____ . ___ kg** ❑ Check here if respondent refuses to have (NAME) weighed

_____
___

(2) CHILD #2: _____ __	❑ Male ❑ Female	_____ / _____ / _____ dd mm yyyy	**_____ . ___ kg**
(3) CHILD #3: _____ ___	❑ Male ❑ Female	_____ / _____ / _____ dd mm yyyy	**_____ . ___ kg**

ONLY FILL IN DATA FOR CHILD #4 IF MOTHER #1 OF (NAME) REFUSES TO HAVE (NAME) WEIGHED

(4) CHILD #4: _____ ___	❑ Male ❑ Female	_____ / _____ / _____ dd mm yyyy	**_____ . ___ kg**

Mozambique Expanded Impact Child Survival Project

Knowledge, Practices, and Coverage (KPC) Survey Questionnaire for

12-23 month old children ONLY

Revised for FINAL EVALUATION

April 30th 2010

Carolyn Wetzel, MPH&TM

Emma Hernandez Avilan, RN

Tom Davis, MPH

INTERVIEWER INSTRUCTIONS:

A. CHOOSE THE STARTING HOUSEHOLD AND ASK ABOUT CHILDREN UNDER TWO. IF YOU FIND NEITHER, THEN GO TO THE NEXT NEAREST HOUSEHOLD.

- IF YOU FIND ONE INFANT (0-11M OLD), THEN INTERVIEW THAT MOTHER AND GO TO THE NEXT NEAREST HOUSE, NEXT NEAREST, ETC. UNTIL YOU FIND A 12-23M OLD. IF YOU FIND A 12-23M OLD FIRST, THEN INTERVIEW THAT MOTHER, THEN GO TO THE NEXT NEAREST HOUSE, NEXT NEAREST, ETC., UNTIL YOU FIND AN INFANT.
- IF YOU FIND *BOTH* AN INFANT AND 12-23M IN A HOUSEHOLD (AND YOU HAVE NOT INTERVIEWED ANY MOTHERS AT THAT SITE), YOU CHOOSE ONE OF THE TWO *AT RANDOM*, INTERVIEW THE MOTHER OF THAT CHILD, THEN GO TO THE NEXT NEAREST HOUSE TO FIND THE MISSING CHILD (i.e., THE CHILD IN THE OTHER AGE GROUP).
- IF YOU FIND SEVERAL CHILDREN IN THE AGE GROUPS (e.g., ONE INFANT AND TWO 12-23M OLDS) AT ONE HOUSEHOLD THEN CHOOSE ONE OF THEM AT RANDOM (VERY IMPORTANT!), THEN GO LOOKING FOR THE MISSING ONE AT A DIFFERENT HOUSEHOLD.
- **ONE IMPORTANT THING** – DO NOT TAKE THE MOTHER OF THE INFANT AND THE MOTHER OF THE 12-23M OLD FROM THE SAME HOUSE. THEY SHOULD BE TWO MOTHERS WHO LIVE IN DIFFERENT HOUSEHOLDS.

B. Selection of Respondent: At the first house chosen for the interview, ask an adult in the household if there are any children who live in the house who are under two years of age. If so, ask for their names and ages. Select one of those children at random, and ask to speak to the mother, or chief caregiver of that child. (If you do not pick one AT RANDOM, it introduces selection bias, and we would have to REPEAT THE ENTIRE STUDY.) CHOOSE THE CORRECT QUESTION-NAIRE TO USE BASED ON THE CHILD'S AGE. This questionnaire is for children 12-23m of age only. Verify that the child is the age that you were originally told (under 24 months) and begin the consent process below. If no child under two is found in the household, proceed to the next nearest house (next nearest door) until a child under 24 months of age is found, and repeat the process above

D. **We want to interview the biological mother if at all possible**. Only interview someone other than the biological mother of the child if the biological mother (1) has died OR (2) has been absent from the child for more than 6 months, OR (3) has give the child to someone else to care for on a regular basis (e.g. because she cannot care the child). (You should SKIP the breastfeeding questions if the main child care provider is not the mother.) If the biological mother normally cares of the child, but she is more than 30 minutes away, choose another child for the interview. Keep track of how many mothers were not at home, and inform your supervisor.

D. **Child's age:** when recoding the child's age in months (**Q. # 9**), be sure to ***ROUND DOWN*** . If this child is 2 months and 30 days, the child is still 2 months. If the child was born on June 15th and today is August 14th the child is still only 2 months old. If the child was born on June 15th and today is June 14th the child is not yet one month old. Please record ZERO for the age in months. Do not record age in weeks – i.e. Two weeks – only in months. If a child is less than one full month of age, record ZERO as the age.

INFORMED CONSENT

Before interviewing a mother or chief caregiver, you must get her/his consent to conduct the interview. Please read the informed consent exactly as it is written. This statement explains the purpose of the survey and the voluntary nature of the respondent's participation, then seeks her/his cooperation. After reading the statement, you (not the respondent) must sign the space provided to affirm that you have read the statement to the mother/chief caregiver. Circle "1" if the mother/chief caregiver agrees to be interviewed and proceed to the modules. If the mother/chief caregiver does not agree to be interviewed, circle "2", thank her/him for her/his time, and end the interview.

INFORMED CONSENT STATEMENT

Hello. My name is _____, and I am working with Food for the Hungry. We are conducting a survey and would appreciate your participation. I would like to ask you about your health and the health of one of your children. This information will help (Food for the Hungry) to assess whether it is meeting its goals to improve children's health. The survey usually takes _____ minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the survey? ***[Answer any questions the mother/chief caregiver has.]***

Do you agree to be interviewed?

RESPONDENT AGREES TO BE INTERVIEWED . . . . . 1 → **DO INTERVIEW**

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED…2 → **END INTERVIEW**

Signature of interviewer: _____

Date: _____ / _____ / _____
dd mm yyyy

Questionnaire Number _____

Interviewer's Name: _____

Supervisor's Name:_____ HH No.: _____

Interview Date:__/___/____ Community: _____

dd mm yyyy

District: _____ Supervision area #: ____

All questions to be asked of <u>Mothers</u> or <u>chief care providers</u> of children <u>12-23 months of months</u> of age

XII. RESPONDENT INFORMATION:

1. Does the mother of this child live with the child? 1. Yes 2. No	***(SPEAK TO THE PRIMARY CARE PROVIDER OF THE CHILD)*** **2. What is your relationship to this child?** **IF mother – prompt biological or adoptive mother?** 1. Biological Mother 2. Adoptive Mother 3. Biological Father 4. Adopted Father 5. Grandmother 6. Aunt 7. Other (Specify: _____)
3. *(Ask respondent:)* How old are you? _____ years	**4. GENDER OF RESPONDENT:**

	❑ Female ❑ Male

NO.	QUESTIONS

43. How many children living in this household are under five years of age?

5. ONE CHILD
6. TWO CHILDREN
7. THREE OR MORE CHILDREN
8. DON'T KNOW/NO REPONSE

44. How many of those children are your biological children?

4. ONE CHILD
5. TWO CHILDREN
6. THREE OR MORE CHILDREN
9. DON'T KNOW/NO RESPONSE

45. What are the, names, sex and date of birth of your two youngest children?

	NAME	SEX	DATE OF BIRTH
1		MALE FEMALE	__ __ / __ __ / _____ dd mm yyyy
2		1. MALE FEMALE	__ __ / __ __ / _____ dd mm yyyy

ALL SUBSEQUENT QUESTIONS PERTAIN TO THE CHILD SELECTED WHO IS 12-23 MONTHS WHEN USING "(NAME)"

***INTERVIEWER**: Explain that you would **later** like to check information on the child's "clinic card" (immunization card/growth monitoring card) and ask her to get them **now** if she has them. The child's clinic card may also have the birth date on it.*

NO.	QUESTIONS

46. What is (NAMES's) date of birth? ***[CONFIRM WITH GM OR IMMUNIZATION CARD]***

____ / ____ / _____ ❑ Don't know

dd mm yyyy

47. How is old is (NAME)? _____ months ❑ Don't know

[NOTE – If the child is 0-11m of age, USE OTHER QUESTIONNAIRE!]

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NO.	QUESTIONS

9.a Is (NAME) male or female?

1. MALE
2. FEMALE
9. DON'T KNOW / NO RESPONSE

48. [SKIPPPED]

49. [SKIPPED]

XIII. WATER AND SANITATION

NO.	QUESTIONS

50. ***[SKIPPED FOR CHILDREN 12-23m OF AGE.]***

51. In the past week, did you do anything to the water given to (NAME) to make it safer to drink? If so, what? (What else?) ***[MULTIPLE ANSWERS ALLOWED]***

A. DID NOTHING / DID NOT TREAT THE WATER
B. BOILED THE WATER
C. ADDED BLEACH / CHLORINE TO THE WATER
D. USED A COMMERCIAL WATER PURIFICATION PRODUCT (e.g., PUR)
E. SIEVED IT THROUGH A FINE CLOTH
F. USED A WATER FILTER (ceramic, sand, composite)
G. USED SOLAR DISINFECTION (left it in the sun)
H. USED SEDIMENTATION (left it so sediment falls to the bottom)
X. OTHER (Please specify:) _____

52. The last time (NAME) passed stool, where did he/she defecate?

1. USED A LATRINE, TOILET, OR IN A SPECIALLY DUG HOLE IN THE GROUND
2. USED POTTY (INDOOR POT OR PAN)
3. USED WASHABLE DIAPERS
4. USED DISPOSABLE DIAPERS
5. WENT ON FLOOR IN HOUSE
6. WENT OUTSIDE OF HOUSE ON THE GROUND (BUT NOT IN A DUG HOLE)
7. WENT IN HIS / HER CLOTHS
8. OTHER (SPECIFY): _____
9. DON'T KNOW

53. **Does your household have a special place for hand washing?**

3. YES
4. NO→**skip to Q. #23**
9. DON'T KNOW/NO RESPONSE→**skip to Q. #23**

54. ***ASK TO SEE THE PLACE USED MOST OFTEN FOR HAND WASHING AND OBSERVE IF THE FOLLOWING ITEMS ARE PRESENT:***

	YES	NO
(A) WATER/TAP	1	2
(B) SOAP, ASH OR OTHER CLEASING AGENT	1	2
(C) BASIN	1	2

55. **When do you wash your hands with soap/ash? (When else?)** ***[MULTIPLE ANSWERS ALLOWED]***

G. DON'T KNOW/NO RESPONSE
H. NEVER
I. BEFORE FOOD PREPERATION
J. BEFORE FEEDING CHILDREN
K. AFTER DEFECATION
L. AFTER ATTENDING TO A CHILD WHO HAS DEFECATED
X. OTHER (SPECIFY)_____

XIV. MATERNAL AND NEWBORN CARE

NO.	QUESTIONS
	[IF RESPONDENT IS NOT THE BIOLOGICAL MOTHER OF (NAME), SKIP TO QUESTION #35]

56. **Before you gave birth to (NAME) did you receive an injection in the arm to prevent the baby from getting tetanus, that is, convulsions after birth?**

3. YES
4. NO→**skip to Q. #20**
9. DON'T KNOW/NO RESPONSE→**skip to Q. #20**

57. **How many times did you receive such an injection?**

1. ONCE
2. TWICE
3. MORE THAN TWO TIMES
9. DON'T KNOW/NO RESPONSE

NO.	QUESTIONS

19b. [SKIPPED]

58. Now I would like to ask you about the time when you gave birth to (NAME). Who assisted you with (NAME'S) delivery? (Who else?) ***[MULTIPLE ANSWERS ALLOWED]***

I. DON'KNOW/CAN'T REMEMBER/NO RESPONSE
J. DOCTOR
K. NURSE/MIDWIFE
L. AUXILIARY MIDWIFE
M. TRADITIONAL BIRTH ATTENDANT
N. COMMUNITY HEALTH WORKER
O. FAMILY MEMBER _____
(SPECIFY RELATIONSHIP TO RESPONDENT)
P. NO ONE
Q. Leader Mother
X. OTHER (SPECIFY:) _____

59. [SKIPPED]

60. [SKIPPED]

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XV. BREASTFEEDING AND INFANT/CHILD NUTRITION

NO.	*QUESTIONS*
	[IF RESPONDENT IS NOT BIOLOGICAL MOTHER OF (NAME), SKIP TO QUESTION #35]

[Questions #23 – 27 are skipped]

28. Are you currently breastfeeding (NAME)?

3. YES
4. NO
9. DON'T KNOW/NO RESPONSE

NO.	*QUESTIONS*

29. For how long did you breastfeed (NAME)?

[IF LESS THAN ONE MONTH, RECORD "00" MONTHS]

___ ____ MONTHS

99. DON'T KNOW/NO RESPONSE

30. Now I would like to ask you about the types of liquids (NAME) drank yesterday during the day and at night. Did (NAME) drink any of the following liquids yesterday during the day or at night?

[READ THE LIST OF LIQUIDS (B THROUGH H, STARTING WITH "BREASTMILK"). CIRCLE THE LETTER IF THE CHILD DRANK THE LIQUID IN QUESTION -- MULTIPLE RESPONSES ALLOWED. PROMPT WITH, "Anything else?" AFTER EACH RESPONSE.]

A. Breastmilk?
B. Plain water?
C. Commercially produced infant formula?
D. Any other milk aside from breastmilk such as powdered milk, tinned milk or fresh animal milk?
E. Fruit juice?
F. Tea or coffee?
G. Traditional medicines that were liquid or semi-liquid?
H. Maheu
I. **Any other liquids?** (SPECIFY:) _____
J. RESPONDENT DOES NOT MENTION ANY LIQUIDS / NO RESPONSES GIVEN

NO.	*QUESTIONS*

31. **I would like to ask you about the food (NAME) ate yesterday during the day and at night, either separately or combined with other foods. Did (NAME) eat any of the following foods yesterday during the day or at night? Anything else?**

[READ THE LIST OF FOODS. CIRCLE THE LETTER IF CHILD ATE THE FOOD IN QUESTION -- MULTIPLE RESPONSES ALLOWED]

T. **Any porridge of gruel?**
U. **Any baby food sold in a bottle or can?**
V. **Any bread, rice, noodles, biscuits, cookies, or ay other food made from grains?**
W. **Any white potatoes, white yams, manioc, cassava, or any other foods made from roots?**
X. **Any pumpkin, carrots, squash or sweet potatoes that are yellow or orange inside?**
Y. **Any dark green leafy vegetables?**
Z. **Any ripe mangoes, papayas (or other local vitamin A-rich fruits?)**
AA. **Any other fruits or vegetables?**
BB. **Any liver, kidney, heart, or other organ meats?**
CC. **Any beef, pork, lamb, goat, rabbit, or other RED meat obtained through hunting?**
DD. **Any chicken, duck, or other birds (including those that are hunted)?**
EE. **Any eggs?**
FF. **Any fresh or dried fish or shellfish?**
GG. **Any foods made from beans, peas, or lentils?**
HH. **Any nuts?**
II. **Any cheese or yogurt?**
JJ. **Any food made with other oil, fat or butter?**
KK. **Any other solid or semi-solid food?**
LL. RESPONDENT DID NOT MENTION ANY FOODS / NO RESPONSES GIVEN

32. **Did (NAME) drink anything from a bottle with a nipple yesterday or last night?**

1. YES
2. NO
9. DON'T KNOW/NO RESPONSE

NO.	*QUESTIONS*

33. How many times did (NAME) eat solid, semi-solid, or soft foods other than liquids yesterday during the day and at night? (What type of food did he/she eat?)

NOTE!:

- ***WE WANT TO FIND OUT HOW MANY TIMES THE CHILD ATE ENOUGH TO BE FULL.***
- ***SMALL SNACKS AND SMALL FEEDS SUCH AS ONE OR TWO BITES OF MOTHER'S OR SISTER'S FOOD SHOULD <u>NOT</u> BE COUNTED.***
- ***LIQUIDS DO <u>NOT</u> COUNT FOR THIS QUESTION.***
- ***DO <u>NOT</u> INCLUDE THIN SOUPS OR BROTH, WATERY GRUELS, OR ANY OTHER LIQUID.***

[USE PROBING QUESTIONS TO HELP THE RESPONDENT REMEMBER ALL THE TIMES THE CHILD ATE YESTERDAY]

__ ___ NUMBER OF TIMES CHILD ATE

❑ DON'T KNOW/NO RESPONSE

34. When you made food for (NAME) yesterday, did you add oil to (NAME's) food?

4. YES
5. NO
6. DID NOT MAKE FOOD FOR CHILD YESTERDAY
9. DON'T KNOW/NO RESPONSE

35. Did (NAME) receive a vitamin A dose like this during the last 6 months?

[SHOW AMPULE/CAPSULE/SYRUP]

3. YES
4. NO
9. DON'T KNOW / NO RESPONSE

XVI. DIARRHEA

NO.	QUESTIONS

36. Has (NAME) had diarrhea in the last 2 weeks?

2. YES
2. NO →**skip to Q. #49**

NO.	QUESTIONS

9. DON'T KNOW/NO RESPONSE

37. What was given to treat the diarrhea or to prevent dehydration? (Anything else?)

[MULTIPLE RESPONSES ALLOWED]

J. DON'T KNOW/NO RESPONSE
K. NOTHING
L. PILL OR SYRUP
M. INJECTIONS
N. IV (INTRAVENOUS) FLUIDS
O. HOME REMEMDIES/HERBAL MEDICINES (given in small amounts of liquid)
P. FLUID FROM THE ORS PACKETS
Q. RECOMMENDED HOME FLUIDS (e.g., water, juice)
R. ZINC TABLETS
X. OTHER (SPECIFY)_____

38. When (NAME) had diarrhea, did you breastfeed him/her less than usual, about the same amount, or more than usual?

1. LESS
3. SAME
4. MORE
5. STOPPED BREASTFEEDING COMPLETELY
6. CHILD NOT BREASTFED AT TIME OF DIARRHEA
9. DON'T KNOW/NO RESPONSE

39. When (NAME) had diarrhea, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?

6. OFFERED LESS
7. OFFERED SAME
8. OFFERED MORE
9. NOT OFFERED ANYTHING TO DRINK (i.e., stopped giving liquids completely)
9. DON'T KNOW/NO RESPONSE

NO.	QUESTIONS

40. When (NAME) had diarrhea, was he/she offered less than usual to eat, about the same amount, or more than usual to eat?

1. OFFERED LESS
2. OFFERED SAME
3. OFFERED MORE
4. NOT OFFERED ANYTHING TO EAT (i.e., stopped giving solid foods completely)
9. DON'T KNOW/NO RESPONSE

41. During the weeks after (NAME) has had diarrhea, after the diarrhea has stopped, do you generally give him/her less than usual to eat, about the same amount, or more than usual to eat?

1. OFFERED LESS
2. OFFERED SAME
3. OFFERED MORE
4. NEVER HAD DIARRHEA
9. DON'T KNOW / NO RESPONSE

42. Have you heard of ORS?

- ***IF YES, ASK MOTHER/CHIEF CARE PROVIDER TO DESCRIBE ORS PREPARATION FOR YOU.***
- ***IF NO, CIRCLE REPONSE 4 (NEVER HEARD OF ORS).***

[ONCE MOTHER/CHIEF CARE PROVIDER HAS PROVIDED A DESCRIPTION, RECORD WHETHER SHE DESCRIBED ORS PREPARATION CORRECTLY OR INCORRECTLY.]

CIRCLE 1 [CORRECTLY] IF THE MOTHER/CHIEF CARE PROVIDER MENTIONED THE FOLLOWING:

- USE 1 LITER OF CLEAN DRINKING WATER (1 LITER=3 SODA BOTTLES)
- USE THE ENTIRE PACKET
- DISSOLVE THE POWDER FULLY

5. DESCRIBED CORRECTLY
6. DESCRIBED INCORRECTLY
7. HEARD OF ORS BUT MOTHER/CHIEF CARE PROVIDER REFUSES TO DESCRIBE PROCESS
8. NEVER HEARD OF ORS

XVII. IMMUNIZATIONS

(Questions on immunizations are integrated in below.)

XVIII. CHILDHOOD ILLNESSES

NO.	QUESTIONS

43. Sometimes children get sick and need to receive care or treatment for illnesses. What are the signs of illness that would indicate your child needs treatment? (Any other signs?)

[MULTIPLE RESPONSES ALLOWED] [EMMA – CHECK AGAINST IMCI PROTOCOL FOR MOZ.]

L. DON'T KNOW/NO RESPONSE
M. LOOKS UNWELL OR NOT PLAYING NORMALLY
N. NOT EATING OR DRINKING
O. LETHARGIC OR DIFFICULT TO WAKE
P. HIGH FEVER
Q. FAST OR DIFFICULT BREATHING
R. VOMITS EVERYTHING
S. CONVULSIONS
T. OTHER (SPECIFY)_____
U. OTHER (SPECIFY)_____
V. OTHER (SPECIFY)_____

XIX. ADDITIONAL RAPID CATCH QUESTIONS

NO.	QUESTIONS

44. Do you have any bed nets in your house?

3. YES
4. NO → **skip to Q. #64**
9. DON'T KNOW → **skip to Q. #64**

45. Who slept under a bed net last night? (Who else?) [*MULTIPLE RESPONSES ALLOWED.]*

A. CHILD (NAME)

B. RESPONDENT

C. OTHER INDIVIDUAL(S) _____

(SPECIFY)

46. Was the bed net ever soaked or dipped in a liquid to repel mosquitoes or bugs?

1. YES

2. NO

9. DON'T KNOW

47. What can a person do to avoid getting AIDS or the virus that causes AIDS? (What else?)

[MULTIPLE RESPONSES ALLOWED]

T. NOTHING
U. ABSTAIN FROM SEX
V. USE CONDOMS
W. LIMIT SEX TO ONE PARTNER/STAY FAITHFUL TO ONE PARTNER
X. LIMIT NUMBER OF SEXUAL PARTNERS
Y. AVOID SEX WITH PROSTITUTES
Z. AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS
AA. AVOID INTERCOURSE WITH PERSONS OF THE SAME SEX
BB. AVOID SEX WITH PERSONS WHO INJECT DRUGS INTRAVENOUSLY
CC. AVOID BLOOD TRANSFUSIONS
DD. AVOID INJECTIONS
EE. AVOID KISSING
FF. AVOID MOSQUITO BITES
GG. SEEK PROTECTION FROM TRADITIONAL HEALER
HH. AVOID SHARING RAZORS, BLADES

NO.	QUESTIONS
	W. OTHER_____ (SPECIFY)
	X. OTHER_____ (SPECIFY)
	Z. DON'T KNOW

XX. GROWTH MONITORING AND CHILD ANTHTROPOMETRY

NO.	QUESTIONS

48. Was (NAME) have a growth monitoring card? IF YES: **May I see it please?**

4. YES, SEEN
5. NOT AVAILABLE / CARD MISPLACED → **skip to Q. #51**
6. NEVER HAD A CARD → **skip to Q. #51**
9. DON'T KNOW/NO RESPONSE → **skip to Q. #51**

49. [Skipped]

50. LOOK AT (NAME) GROWTH MONITROING CARD AND SEE IF (NAME) HAS BEEN WEIGHED <u>IN THE LASTS FOUR MONTHS</u>

1. YES
2. NO
9. CANNOT DETERMINE FOR SURE

51. [ASK FOR CHILDREN 12 MONTHS AND OLDER:]

Has (NAME) received a medicine for worms in the last six months?

1. YES
2. NO
9. DON'T KNOW

X. OTHER KPC QUESTIONS BASED ON MINI-KPC

NO.	QUESTIONS

52. [Skipped]

53. [Skipped]

54. What are the signs of danger after giving birth indicating the need for you to seek health care? ***[MULTIPLE ANSWERS ALLOWED]***

A. FEVER
B. EXCESSIVE BLEEDING
C. SMELLY VAGINAL DISCHARGE
D. DON'T KNOW/NO RESPONSE
X. OTHER (SPECIFY)_____

55. When breastfeeding (NAME) do you offer both breasts?

NO.	QUESTIONS

1. YES
2. NO→**skip to Q. #57**
9. DON'T KNOW/NO RESPONSE→**skip to Q. #57**

56. **When breastfeeding (NAME) do you usually completely empty both breasts?**

1. YES
2. NO
9. DON'T KNOW/NO RESPONSE

57. **How do you keep food after you prepare it?**

1. MENTIONS COVERING IT OR REFRIGERATING IT
2. DOES NOT MENTION COVERING IT OR REFRIGERATING IT
9. DON'T KNOW/NO RESPONSE

58. **During the past two weeks, have you received a visit from you Leader Mother?**

1. YES
2. NO
3. RESPONDENT IS THE LEADER MOTHER
9. DON'T KNOW/NO RESPONSE

59. **How soon after a child is born how soon should the mother start to breastfeed? (Quanto tempo depois do parto uma mãe deve por sua criança à mamar?)**

1. IMEDIATAMENTE/DENTRO DA PRIMEIRA HORA APÓS O PARTO
2. DEPOIS DA PRIEIRA HORA APÓS O PARTO
9. NÃO SABE / NÃO RESPONDEU

60. **In your opinion, does breastfeeding while you are pregnant endanger your child in any way? (Na sua opiniao, voce esta a perjudicar a sua crianca de alguma maneira se a amamenta duante uma nova gravidez ?)**

1. SIM
2. NÃO
9. NÃO SABE/NÃO RESPONDEU

61. **Do you believe that men have more value than women, that women have more value than men, or that they are equal? (Voce acredita que vale mais a homen que a mulher, vale mais a**

NO.	QUESTIONS

mulher que a homen, o sao iguais ?)

1. HOMEN VALE MAIS
2. MULHER VALE MAIS
3. SAO IGUAIS
9. NÃO SABE / NÃO RESPONDEU

62. If a mother knows that she is HIV+, how should she feed her child for the first six months? (Se por acaso uma mãe tem conhecimento que e HIV+, como iria alimentar a sua criança ate atingir os seis meses de idade ?)

1. DA SO LEITE MATERNA , SIM OUTORS LIQUIDOS O COMIDA
2. DA LEITE MATERNA E OUTRAS COMIDAS OU LIQUIDOS
3. OUTRA RESPOSTA (INOCRRECTA). QUAL? _____
9. NÃO SABE/NÃO RESPONDE

63. How can a woman prevent anemia during pregnancy? (Multiple responses allowed) (Como pode a mulher prevenir a anemia durante a gravidez? [SÃO PERMITIDAS MÚLTIPLAS RESPOSTAS])

1. Eat food rich in iron, such as red meat, bird meat, and green leaves (Comer comidas ricas em ferro como carnes, aves, e folhas verdes)
2. Eat iodized salt (Comer Sal idoado)
3. Take supplements of iron and folic acid (Tomar suplementos com ferro e acido folico)
4. Sleep under a mosquito net (Dormir embaixo da rede mosquiteira)
9. NÃO SABE/NÃO RESPONDE

64. Did you child have a fever in the last two weeks? (A sua criança teve Febres nas ultimas duas semanas?)

1. Sim
2. Nao → **Saltar para a Pergunta #67**
9. Nao Sabe/ Nenhuma Resposta

65. Did you seek advice or treatment when your child had a fever? (Se Sim, você procurou aconselhamento ou tratamento quando a criança teve febre?)

NO.	QUESTIONS

1. Sim

2. Nao → **Saltar para a Pergunta #67**

9. Nao Sabe/ Nenhuma Resposta

66. **Who or where did you see help when your child had a fever in the last two weeks? [Multiple answers allowed] Se Sim, de quem/onde voçê procurou ajuda quando a sua criança teve febre na ultimas duas semanas? [assinale todas respostas dadas]**

A. Traditional Healer / witchdoctor (Curandeiro Tradicional)

B. Government Hospital (Hospital do Governo)

C. Health Post (Unidade Sanitaria)

D. Religious Leader (Lideres Religiosos)

E. Private doctor or nurse (Médico/Enfremeiro Privado)

F. Pharmacy (Farmácias)

G. Lead Mother trained in C-IMCI (Mae ACS)

H. Leader Mother NOT trained in C-IMCI

H. Traditional Birth attendant (Parteira Tradicional)

I. Parents or friends (Parentes, amigos (pessoas de fora))

J. Nao Sabe/ Nenhuma Resposta

67. **What causes Malaria? (O que provoca a Malaria?)**

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A. The bite from a mosquito /Pela picada de um mosquito

B. Withcraft /Feitiçaria

C. The use of interavenous drugs /Uso de drogas intravenosas

D. Blood transfusions/Transfusões de sangue

E. Injections /Injeções

F. Sharing razors/ Partilha de laminas

G. Cough /Pela tosse

H. Outro _____ (Especifique)

NO.	QUESTIONS
	E. Nao Sabe/ Nenhuma Resposta
68.	**Check the Growth Card:** **How many DPT doses does (NAME) have? Has (NAME) received measles vaccine?** ___ doses of DPT vaccine registradas no seu cartão ___ doses of Measles vaccine registradas no seu cartão ❑ Falta cartão

XI. HEALTH CONTACTS AND SOURCES OF HEALTH INFORMATION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES		
69.	**During the last month, how often have you come in contact with each of the following:**	FREQUENTLY (4 or more times)	SOMETIMES (1-3 times)	NEVER (0 times)
	Doctor	1	2	3
	Nurse/Midwife	1	2	3
	Leader Mother / Health Educator /CHW	1	2	3
	Trained Birth Attendant	1	2	3
	Traditional Healer	1	2	3
70.	**From where do you get general information or advice on health or nutrition?**	**Formal Network**		
	RECORD ALL MENTIONED.	Doctor		A
		Nurse/Midwife		B
		Leader Mother / Health Educator / CHW		C
		Trained Birth Attendant		D

		Informal Network	
		Husband/Partner	E
		Mother/Mother-In-Law	F
		Sister	G
		Grandparent	H
		Aunt	I
		Friend/Neighbor	J
		Traditional Healer	K
		Village Elder	L
		OTHER _____ (Specify)	X

71. **In the past month, have you received any health messages from any of the following sources?** ***(READ ALL RESPONSES AND CIRCLE ALL THAT ARE YES)***

A. Radio?
B. Newspaper?
C. Television?
D. Leader Mother?
E. Other Health Educator or CHW?

72. **May I weigh (NAME)?**

[ALSO ASK TO WEIGH ANY CHILDREN IN THE SAME HOUSEHOLD THAT ARE ALSO UNDER 12 MONTHS OF AGE.]

1. YES → **Proceed to #73 and weigh child**
2. NO → **END INTERVIEW**

ANTHROPOMETRY

Record weights of all children 12-23 months in (NAME'S) household. If there are less than three children 12-23 months of age in the household, go to the next nearest household from the front entrance of (NAME'S) house and check to see if that household contains any children 12-23 months of age. If there are children 12-23m of age there, ask the mother's/chief care provider's consent, and weigh the children 12-

23m of age in that house. Continue going to the next nearest household from the front entrance of the last house visited until a total of <u>three children</u> 12-23m of age have been weighed. Then conduct the interview of a mother/chief care provider of a child 0-11m of age (if you have not done so already). (The mother/chief care provider of the child 0-11m of age should NOT be the same mother/chief care provider as the mother/chief care provider of the child 12-23m of age that you interviewed.)

73. NAME OF CHILD (WEIGH [NAME] FIRST THEN WEIGHT OTHER CHILDREN IN THE HOUSEHOLD WHO ARE 12-23 MONTHS OF AGE	**GENDER**	**What is his/her date of birth?** COPY DATEOF BIRTH FROM G/M CARD IF IT IS AVAILBALE. IF G/M CARD IS NOT AVAILABLE RECORD DATE OF BIRTH PROVIDED BY MOTHER/CHIEF CARE PROVIDER	WEIGHT (KG)
1. NAME OF CHILD IN <u>FIRST</u> HOUSEHOLD (WHERE INTERVIEW OF 12-23m OLD WAS CONDUCTED): _____	❑ Male ❑ Female	_____ / _____ / _____ dd mm yyyy	**_____ . ___ kg** ❑ Check here if respondent refuses to have (NAME) weighed
(2) CHILD #2: _____	❑ Male ❑ Female	_____ / _____ / _____ dd mm yyyy	**_____ . ___ kg**
(3) CHILD #3: _____	❑ Male ❑ Female	_____ / _____ / _____ dd mm yyyy	**_____ . ___ kg**

ONLY FILL IN DATA FOR CHILD# 4 IF MOTHER OF CHILD #1 (NAME) REFUSES TO HAVE (NAME) WEIGHED

(4) CHILD #4: _____	❑ Male ❑ Female	_____ / _____ / _____ dd mm yyyy	**_____ . ___ kg**

F. PORTUGUESE QUESIONNAIRES

Mozambique Impacto Expandido

Projeto de Sobrevivência Infantil

Conhecimento, Práticas, e Cobertura (KPC)

Questionário de Pesquisa para

Crianças 0-11 m de Idade

Revisado só para AVALIAÇÃO FINAL

30 de abril 2010

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Emma Hernandez Avilan, RN

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INSTRUCÕES PARA O ENTREVISTADOR

A. ESCOLHA A CASA PARA COMEÇO E PERGUNTE POR CRIANÇAS ABAIXO DE DOIS ANOS. SE VOCÊ NAO ACHAR NENHUM, ENTÃO VÁ PARA A PRÓXIMA CASA MAIS PERTO.

SE VOCÊ ENCONTRAR UMA CRIANÇA (0-11M DE IDADE), ENTÃO ENTREVISTE ESSA MÃE E VAI PARA A CASA A SEGUIR MAIS PERTO, MAIS PRÓXIMA A SEGUIR, ETC. ATÉ QUE VOCÊ ACHE UMA DE 12-23M DE IDADE. SE VOCÊ ACHAR PRIMEIRO UMA DE 12-23M DE IDADE, ENTÃO ENTREVISTE ESSA MÃE, DEPOIS VÁ PARA A PRÓXIMA CASA MAIS PERTO, A SEGUIR MAIS PRÓXIMO, ETC., ATÉ QUE VOCÊ ACHE UMA BEBE 0-11M DE IDADE.

SE VOCÊ ACHA UM BEBE E UMA DE 12-23M EM UMA CASA (E VOCÊ NÃO ENTREVISTOU NENHUMA MÃE NAQUELE LOCAL), VOCÊ ESCOLHE UM DOS DOIS AO ACASO (ALEATORIAMENTE), ENTREVISTE A MÃE DAQUELA CRIANÇA, ENTÃO VÁ PARA A PRÓXIMA CASA MAIS PERTO PARA ACHAR A CRIANÇA QUE FALTA.

SE VOCÊ ACHA UM BEBE DE 0-11M E DUAS DE 12-23M DE IDADE EM UMA CASA, POR EXEMPLO, ENTÃO ESCOLHA UM DOS TRÊS AO ACASO, DEPOIS VÁ PROCURAR A QUE FALTA NUMA CASA DIFERENTE.

UMA COISA IMPORTANTE - NÃO LEVE A MÃE DO BEBE E A MÃE DA DE 12-23M DE IDADE DA MESMA CASA. ELAS DEVERIAM SER DUAS MÃES QUE MORAM EM CASAS DIFERENTES.

B. <u>Selecção de Respondente</u>: Na primeira casa escolhida para entrevista, pergunte a um adulto na casa se há alguma criança vivendo em casa que tenha abaixo de dois anos de idade. Se existir, pergunte os seus nomes e idades. Seleccione uma dessas criaças <u>aleatoriamente</u>, e peça para falar com a mãe dessa criança. **ESCOLHA O QUESTIONÁRIO CORRETO PARA USAR BASEADO NA IDADE DA CRIANÇA.** Este questionário é para crianças de **0-11m** de idade somente. Se vai usar este questionário, verifique se a criança tem a idade que foram originalmente ditos (<u>abaixo de 24 meses</u>) e inicia o processo de consentimento abaixo. Se não encontrar nenhuma criança abaixo de dois anos na casa, prossiga para a casa a seguir mais próxima (a porta a seguir mais próxima) até que uma crança abaixo de 24 meses de idade seja achada e repita o processo acima.

C. Nós queremos entrevistar a mãe biológica se possível. Só entrevista alguém que não seja a mãe biológica da criança se a mãe biológica (1) morreu (2) esteve ausente da criança para mais de 6 meses, ou (3) deu a criança a outra pessoa cuidar regularmente (ex. porque ela não pode cuidar da criança). (Nós saltaremos as perguntas de amamentação se o principal provedor de cuidado da criança não for a mãe.) Se a mãe biológica cuida da criança regularmente, mas está a mais de 30 minutos de distancia, escolha outra criança para a entrevista.

D. A idade da criança: ao registar a idade da criança em meses **(P. #9)**, tenha a certeza de **arredonda-los para baixo**. Se esta criança tiver 2 meses e 30 dias, a criança ainda tem 2 meses. Se a criança nascesse no dia 15 de junho e hoje é 14 de agosto a criança ainda tem só **1** mes de idade.

Se a criança nascesse no dia 15 de junho e hoje é 14 de julho a criança ainda não tem um mês de idade. Por favor registe ZERO para a idade em meses. Não registre idade em semanas - i.e. Duas semanas - só em meses. Se uma criança tem menos de um mês completo de idade, registe ZERO.

CONSENTIMENTO

Antes de entrevistar uma mãe, você deve ter o consentimento dela para efectuar a entrevista. Por favor leia o consentimento informado exactamente como está escrito. Esta afirmação explica o propósito do inquérito e a natureza voluntária da participação do entrevistado. Peça a mãe a colaboração dela. Após a leitura da afirmação, você (não o respondente) deve sinalizar o espaço providenciado para afirmar que leu a afirmação para a mãe/provedora de cuidados chefe. Circule "1" se a mãe/provedora de cuidados chefe aceita ser entrevistada e prossiga aos modules. Se a mãe/provedora de cuidados chefe não aceita ser entrevistada, agradeça a ela pelo tempo, termine a entrevista, e vá para a próxima casa mais perto.

DECLARAÇÃO DE CONSENTIMENTO

Bom dia/Boa tarde. O meu nome é _____, e estou a trabalhar com a Fundação Contra Fome. Estamos a fazer uma pesquisa e gostaríamos de ter a sua participação. Eu gostaria de lhe perguntar acerca da sua saúde e a saúde de sua criança mais nova abaixo de dois anos de idade. Estas informações ajudarão (Fundação Contra Fome) a planear serviços de saúde e avaliar se está indo ao encontro de suas metas para melhorar a saúde de crianças. A pesquisa normalmente leva_____ minutos para completar. Qualquer informações que você providenciar serão mantidas estritamente confidencial e não serão mostradas a outras pessoas.

A participação nesta pesquisa é voluntária e poderá escolher não responder qualquer pergunta individual ou todas as perguntas. Porém, nós esperamos que você participará nesta pesquisa porque suas opiniões são

importantes.

Quer fazer alguma pergunta acerca da pesquisa? ***[Responda qualquer pergunta que a mãe tiver.]***

Você concorda ser entrevistado?

RESPONDENTE CONCORDA SER ENTREVISTADO. . . . . 1 → **ENTREVISTE**

RESPONDENTE NÃO CONCORDA SER ENTREVISTADO …2 → **TERMINE A ENTREVISTA**

Assinatura do entrevistador: _____

Data: _____ / _____ / _____
dd mm aaaa

Questionário Número _____

Nome do Entrevistador:_____

Nome do Supervisor:_____ No AF.:_____ GC n° _____

Data da Entrevista: ____/___/____ Comunidade: _____ Distrito: _____
dd mm aaaa

Todas perguntas devem ser feitas a <u>Mães</u> ou <u>provedores de cuidado chefe</u> de crianças de menos de 12 meses de idade.

I. INFORMAÇÃO DO RESPONDENTE

i. A mãe desta criança vive com a criança? 1. Sim 2. Não	***(FALE COM O PRINCIPAL CUIDADORA DA CRIANÇA)*** **2. Qual a sua relação com esta criança?** **(*Se for mãe - sondar* – Se é mãe biológica ou adoptiva?)** 1. Mãe Biológica 2. Mãe Adoptiva 3. Pai 4. Avó 5. Tia 6. Outro (Especifique:)_____
3. *(Pergunte a respondente)* Que idade tem? _____ anos 9. NÃO SABE/NENHUMA RESPOSTA	**4. GÊNERO DO RESPONDENTE:** ❑ Feminino ❑ Masculino

N°.	PERGUNTAS

5.	**Quantas crianças das que moram na sua casa são menores de cinco anos de idade?** 9. UMA CRIANÇA 10. DUAS CRIANÇAS 11. TRÊS OU MAIS CRIANÇAS 9. NÃO SABE/NENHUMA RESPOSTA
6.	**Quantas dessas crianças são suas crianças biológicas?** 7. UMA CRIANÇA 8. DUAS CRIANÇAS 9. TRÊS OU MAIS CRIANÇAS 9. NÃO SABE/NENHUMA RESPOSTA
7.	**Quais são os nomes, sexo e data de nascimento das tuas duas crianças mais novas?**

	NOME	**SEXO**	**DATA DE NASCIMENTO**
1		1. MASC. 2. FEM.	__ __ / __ __ / _____ dd mm aaaa
2		1. MASC. 2. FEM.	__ __ / __ __ / _____ dd mm aaaa

TODAS PERGUNTAS SUBSEQÜENTES PERTENCEM À CRIANÇA SELECIONADA COM MENOS DE UM ANO DE IDADE. DEVE SE USAR O " (NOME)"

*ENTREVISTADOR: Explique que você gostaria **depois** de verificar a informação no "cartão de saúde" da criança (cartão de imunização de cartão monitora de crescimento) e peça **para ver** se ela os tiver. O cartão de clínica da criança também pode ter a data de nascimento.*

N.°	QUESTIONS
8.	**Qual é a data de nascimento de (NOME) ?** ***[CONFIRME COM O CARTÃO DE SAÚDE]*** ____ / ____ / _____ ❑ Cartão não disponível 9. NÃO SABE/NENHUMA RESPOSTA dia mes ano
9.	**Que idade tem (NOME)?** _____ meses ❑ NÃO SABE/NENHUMA RESPOSTA ***[NOTA - Se a criança for 12-23m de idade, USE OUTRO QUESTIONÁRIO!]***
9.a	**Sexo da criança?** 1. MASCULINO

	2. FEMININO 9. NÃO SABE/NENHUMA RESPOSTA
10.	**Durante quantos anos você frequentou a escola?** _____ anos ***[SE NUNCA REGISTE '00'; SE NÃO SABE, REGISTE '99']***
11.	**Quem cuida de (NOME) quando você está fora de casa?** **(Se ninguém mais, marque "4" abaixo. Se alguém mais para além da mãe, Pergunte:)** **Essa pessoa ouviu os ensinos da Mãe chefe em grupo ou durante uma visita domiciliaria no último mês?** **10.** SIM, ESSA PESSOA OUVIU O ENSINO DA MÃE DE CHEFE NO MÊS PASSADO **11.** NÃO, ESSA PESSOA NÃO OUVIU O ENSINO DA MÃE CHEFE NO MÊS PASSADO **12.** NÃO SABE/NENHUMA RESPOSTA **13.** NENHUMA OUTRA PESSOA CUIDA DA CRIANÇA **14.** MÃE CHEFE NÃO FEZ VISITA DOMICILIARIA OU ENSINO EM GRUPO NO ÚLTIMO MÊS.

II. AGUA E SANEAMENTO

NO.	PERGUNTAS
12.	**Agora eu gostaria de lhe fazer algumas perguntas acerca da sua casa. Qual é a principal fonte de água de beber para os membros de sua casa?** 1. CANALIZADA ATÉ A RESIDENCIA / QUINTAL / TERRENO 2. TORNEIRA PUBLICA 3. POÇO ABERTO NA RESIDÊNCIA / QUINTAL / TERRENO 4. POÇO PÚBLICO 5. POÇO PROTEGIDO NA RESIDÊNCIA / QUINTAL / TERRENO 6. POÇO PUBLICO PROTEGIDO 7. FONTENÁRIA / RIO / AFLUENTE 8. LAGOA / LAGO / BARRAGEM 9. AGUA DA CHUVA 10. OUTRO (ESPECIFIQUE)_____ 99. NÃO SABE / NENHUMA RESPOSTA

13. **Na semana passada, você fez qualquer coisa à agua dada a (NOME) para torná-la segura para beber? Se fez, o quê? (O que mais?)** ***[PERMITE-SE RESPOSTAS MULTIPLAS]***

A. NÃO FEZ NADA / NÃO TRATOU A ÁGUA
B. FERVEU A ÁGUA
C. ADICIONOU JAVEL / CLORO NA AGUA
D. USOU UM PRODUTO COMERCIAL PARA PURIFICAÇÃO DE AGUA (ex., CERTEZA)
E. FILTROU ATRAVÉS DUM PANO LIMPO
F. USOU UM FILTRO DE AGUA (cerâmica, areia, composto)
G. USOU DESINFECÇÃO SOLAR (deixou no sol)
H. USOU SEDIMENTAÇÃO (deixou assim e sedimento caiu/desceu ao fundo)
X. OUTRO (Por favor especifique:) _____

14. **A última vez que (NOME) fez necessidades maiores, onde foi que ele/ela defecou?**

1. USOU UMA LATRINA, CASA DE BANHO OU NUMA COVA ESPECIALMENTE CAVADA NO CHÃO
2. USOU PINICO (PINICO DE DENTRO DE CASA)
3. USOU FRALDAS LAVAVEIS
4. USOU FRALDAS DESCARTÁVEIS
5. FEZ NO CHÃO DENTRO DA CASA
6. FOI PARA FOR A DA CASA NO CHÃO (MAS NÃO NUMA COVA FEITA)
7. FEZ NA ROUPA
8. OUTRO (ESPECIFIQUE): _____
9. NÃO SABE/ NENHUMA RESPSTA

15. **A sua casa tem um lugar especial para lavar mãos?**

5. SIM
6. NÃO→**salta para P. # 17**
9. NÃO SABE / NENHUMA RESPSTA→**salta para P. # 17**

16. ***PEÇA PARA VER O LUGAR USADO MAIS FREQUENTEMENTE PARA LAVAGEM DAS MÃOS E OBSERVA SE OS SEGUINTES ITENS ESTÃO PRESENTES:***

	SIM	NÃO
(A) AGUA/TORNEIRA	1	2
(B) SABÃO, CINZA OU OUTRO DETERGENTE DE LAVAGEM	1	2
(C) BACIA	1	2

17.	**Quando você lava suas mãos com sabão/cinza? (Quando mais?)** ***[PERMITE-SE RESPOSTAS MULTIPLAS]*** M. NÃO SABE/NENHUMA RESPOSTA N. NUNCA O. ANTES DE PRERARAÇÃO DA COMIDA P. ANTES DE DAR DE COMER AS CRIANÇAS Q. DEPOIS DE DEFECAR R. DEPOIS DE CUIDAR DE UMA CRIANÇA QUE DEFECOU X. OUTRO (ESPECIFIQUE)_____

III: CUIDADOS MATERNO INFANTIL

N°	PERQUNTAS
	[SE RESPONDENTE NÃO É A MÃE BIOLÓGICA DE (NOME), SALTA PARA PERGUNTA #30]
18.	**Antes de você dar à luz a (NOME) recebeu uma injecção no braço para prevenir o bebé de apanhar tétano, ou seja, convulsões depois de nascimento?** 5. SIM 6. NÃO→**salta para P. # 19 b.** NÃO SABE/NENHUMA RESPOSTA→**salta para P. # 19 b.**
19.	**Quantas vezes você recebeu tal injecção?** 1. UMA VEZ 2. DUAS VEZES 3. MAIS QUE DUAS VEZES 9. NÃO SABE /NENHUMA RESPOSTA
19 b.	**Quando você deu à luz a (NOME), você recebeu em sua casa visita da Mãe chefe ou de um trabalhador de saúde durante a PRIMEIRA SEMANA depois do parto?** 1. SIM 2. NÃO 9. NÃO SABE /NENHUMA RESPOSTA

20.	**Agora gostaria de lhe perguntar acerca do tempo em que deu a luz à (NOME). Quem a assistiu durante o parto de (NOME)? (Quem mais?)** ***[PERMITE-SE RESPOSTAS MÚLTIPLAS]*** R. NÃO SABE/NÃO SE LEMBRA/NENHUMA RESPOSTA S. MÉDICO

	T. ENFERMEIRA/PARTEIRA U. ASSISTENTE DE PARTEIRA V. PARTEIRA TRADICIONAL W. TRABALHADOR DE SAÚDE DA COMUNIDADE x. MEMBRO DA FAMÍLIA _____ (ESPECIFIQUE RELACIONAMENTO COM RESPONDENTE) Y. NINGUÉM Z. MÃE CHEFE X. OUTRO (ESPECIFIQUE:) _____
21.	**Quando você estava grávida de (NOME), durante quantos dias tomou suplementos férreos (sal ferroso)?** ***[MOSTRE COMPRIMIDOS]*** ***[SE O RESPONDENTE MENCIONAR MESES, CONVERTA PARA DIAS MULTIPLICANDO POR 30.]*** _____ dias 99. Não sabe / Nenhuma resposta
22.	**Quando você estava gravida de (Nome) quantas consultas pré-natal fez?** ____ meses ❑ Não sabe / Nenhuma resposta

IV: AMAMENTAÇÃO E NUTRIÇÃO INFANTIL/CRIANÇA

N°	PERGUNTAS
	[SE O RESPONDENTE NÃO É MÃE BIOLOGICA DE (NOME), SALTE PARA PERGUNTA #30]
23.	**Você já alguma vez amamentou (NOME)?** 3. SIM 4. NÃO→ **Salte para P. #30** 9. NÃO SABE/NENHUMA RESPOSTA→**salta para P. #30**
24.	**Depois de quanto tempo após o nascimento (Nome) você pôs no peito para mamar?** 4. IMEDIATAMENTE/DENTRO DA PRIMEIRA HORA APÓS O PARTO 5. ENTRE 1 E 8 HORAS 6. DEPOIS DAS PRIMEIRAS OITO HORAS 10. NÃO SABE/NENHUMA RESPOSTA
25.	**Durante os primeiros três dias após o parto, você deu a (NOME) o liquido que saia dos seus seios?** 3. SIM 4. NÃO 9. NÃO SABE/NENHUMA RESPOSTA
26.	**Durante os primeiros três dias após o parto, você deu a (NOME) qualquer outra coisa para comer ou beber antes de alimentá-lo/a com leite materno?** 3. SIM 4. NÃO → **Salte para P. #** 28 9. NÃO SABE/NENHUMA RESPOSTA

N°	PERGUNTAS
27.	**Durante os primeiros três dias após o parto, o que você deu a (NOME) para comer ou beber?** ***[NÃO LEIA A LISTA. MARCA TUDO O QUE A MÃE MENCIONA. INCITE COM " qualquer outra coisa "? DEPOIS DE CADA RESPOSTA]*** ***[PERMITE-SE RESPOSTAS MULTIPLAS]*** I. NÃO SABE/NENHUMA RESPOSTA J. LEITE (PARA ALÉM DE AMAMENTAÇÃO) K. SOMENTE AGUA L. AGUA COM AÇÚCAR E/OU SAL M. SUMO DE FRUTA N. CHÁ/ INFUSÕES O. MEDICAMENTOS TRADICIONAIS LIQUIDOS OU SEMI-LIQUIDOS P. FÓRMULA INFANTIL XI. OUTRO (ESPECIFICA)_____
28.	**Você está actualmente amamentando a (NOME)?** **5.** SIM (salte para #30) 6. NÃO 9. NÃO SABE/NENHUMA RESPOSTA
29.	**Por quanto tempo você amamentou (Nome)?** ***[SE MENOS DE UM MÊS, REGISTE "00" MESES]*** ___ ____ MESES 9. NÃO SABE/NENHUMA RESPOSTA

N°	PERGUNTAS
30.	**Agora gostaria de lhe perguntar acerca dos tipos de líquidos que (NOME) bebeu ontem durante o dia e à noite. Será que (NOME) bebeu qualquer dos seguintes líquidos ontem durante o dia e à noite?** ***[LEIA A LISTA DE LÍQUIDOS (B ATÉ H, COMEÇANDO COM "LEITE MATERNO"). CIRCULE A LETRA SE A CRIANÇA BEBEU O LÍQUIDO EM QUESTÃO -- PERMITE-SE MULTIPLA RESPOSTA.*** A. Leite materno? B. Agua? C. Formula infantil comercialmente produzida? D. Qualquer outro leite além de leite materno como leite em pó, ou leite fresco de origem animal? E. Sumo de Fruta ? F. Chá ou café? G. Medicamentos tradicionais líquidos ou semi- líquidos? H. Maheu I. Qualquer outro líquido? **(ESPECIFIQUE:)** _____ J. RESPONDENTE NÃO MENCIONA LÍQUIDO / NENHUMA RESPOSTA DADA

N°	QUESTIONS
31.	**Gostaria de lhe perguntar acerca da comida que (NOME) comeu ontem durante o dia e à noite, quer separadamente ou associada com outras comidas. Será que (NOME) comeu quaisquer das comidas seguintes ontem durante o dia ou à noite? Qualquer outra coisa?** ***[LEIA ESTA LISTA DE COMIDAS. CIRCULE A LETRA SE A CRIANÇA COMEU A COMIDA EM QUESTÃO --PERMITE-SE RESPOSTAS MÚLTIPLAS]*** **MM.** Sopa de aveia? **NN.** Qualquer [NOME DE MARCA DE COMIDA DE BEBÊ COMERCIALMENTE FORTALECIDA, ex. Cerelac] **OO.** Pão, arroz, macarrão, bolachas, biscoitos, ou qualquer outra comida feita de grãos? **PP.** Batata branca, inhames brancos, mandioca, ou qualquer outra comida feita de raízes? **QQ.** Abóbora, cenoura, batata doce de polpa alaranjada? **RR.** Legume verde escuro? **SS.** Manga madura ou papaia? **TT.** Outra fruta ou vegetais? **UU.** Fígado, rim, coração, ou outro órgãos de origem animal? **VV.** Carne de boi, carne de porco, cordeiro, cabra, coelho (ou insere carne de caça) **WW.** Galinha, pato, ou outras aves? **XX.** Ovos? **YY.** Peixe fresco ou seco ou mariscos? **ZZ.** Comida feita de feijões, ervilhas, ou lentilhas? **AAA.** Nozes? **BBB.** Queijo ou iogurte? **CCC.** Comida feita com outro tipo de óleo, gordura ou manteiga? **DDD.** Qualquer outra comida sólida ou semi - sólida? **EEE.** RESPONDENTE NÃO MENCIONOU NENHUMA COMIDA / NENHUMA RESPOSTA DADA
32.	**Será que (NOME) bebeu qualquer coisa de um beberom ontem ou na noite passada?** 1. SIM 2. NÃO 9. NÃO SABE/NENHUMA RESPOSTA

33.	**Quantas vezes (NOME) comeu comidas sólidas, semi - sólidas, ou macias diferente de líquidos ontem durante o dia e à noite? (Que tipo de comida comeu ele/ela?)** ***NOTA!:*** • ***NÓS QUEREMOS DESCOBRIR QUANTAS VEZES A CRIANÇA COMEU O SUFICIENTE PARA ESTAR SACIADA.*** • ***LANCHES PEQUENOS E ALIMENTOS PEQUENOS COMO UMA OU DUAS MORDIDAS NA COMIDA DA MÃE OU IRMÃ <u>NÃO</u> DEVERIAM SER CONTADAS.*** • ***LÍQUIDOS NÃO CONTAM PARA ESTA PERGUNTA.*** • ***<u>NÃO</u> INCLUA SOPAS MAGRAS OU CALDO, SOPAS DE AVEIA AGUADAS, OU QUALQUER OUTRO LÍQUIDO.*** **[USE PERGUNTAS QUE SONDA PARA AJUDAR O RESPONDENTE A SE LEMBRA TODAS AS VEZES QUE A CRIANÇA COMEU ONTEM]** __ ___ NUMERO DE VEZES QUE A CRIANÇA COMEU 99. NÃO SABE/NENHUMA RESPOSTA
34.	**Quando você fez comida para (NOME) ontem, adicionou óleo à comida dele?** 7. SIM 8. NÃO 9. NÃO FEZ COMIDA PARA CRIANÇA ONTEM 9. NÃO SABE/NENHUMA RESPOSTA

35.	**A (NOME) recebeu uma dose de vitamina A como esta durante os últimos 6 meses?** ***[MOSTRE AMPOLA/CAPSULA/XAROPE]*** 5. SIM 6. NÃO 9. NÃO SABE / NENHUMA RESPOSTA

V. DIARREA

N°	PERGUNTAS
36.	**A (NOME) teve diarreia nas últimas 2 semanas**? 7. SIM 2. NÃO →**Salta para P. # 42** 9. NÃO SABE/NENHUMA RESPOSTA

N°	PERGUNTAS
37.	**O que foi dado para tratar a diarréia ou prevenir desidratação? (Qualquer outra coisa?)** ***[PERMITE-SE RESPOSTAS MÚLTIPLAS]*** S. NÃO SABE/NENHUMA RESPOSTA T. NADA U. COMPRIMIDOS OU XAROPE (DIFERENTE DE ZINCO) V. INJEÇÕES W. LÍQUIDOS (INTRAVENOSOS) X. REMEDIOS CASEIROS/MEDICAMENTOS A BASE DE ERVAS (dados em pequenas quantidades) Y. SRO EM PACOTE Z. LIQUIDOS CASEIROS RECOMENDADOS – AGUA, SUMO, ETC. AA. TABLETES DE ZINCO X. OUTRO (ESPECIFIQUE)_____
38.	**Quando (NOME) teve diarreia, você amamentou a ela/ele menos que o habitual, a mesma quantidade, ou mais que o habitual?** 1. AMAMENTOU MENOS 8. AMAMENTOU A MESMA QUANTIDADE 9. AMAMENTOU MAIS 10. CRIANÇA NÃO MAMOU 9. NÃO SABE/NENHUMA RESPOSTA
39	**Quando (NOME) teve diarreia, deu a ele/ela beber menos que o habitual, a mesma quantidade ou mais que o habitual ?** **15.**DEU A BEBER MENOS **16.**DEU A BEBER A MESMA QUANTIDADE **17.**DEU A BEBER MAIS **18.**NÃO DEU <u>NADA</u> PARA BEBER (ex., parou de dar líquidos completamente) 9. NÃO SABE/NENHUMA RESPOSTA
40	**Quando (NOME) teve diarreia, deu a ele/ela a comer menos que o habitual, a mesma quantidade, ou mais que o habitual ?** 1. DEU A COMER MENOS 2. DEU A COMER A MESMA QUANTIDADE 3. DEU A COMER MAIS 4. NÃO DEU <u>NENHUMA COISA</u> PARA COMER (ex., parou de dar alimentos sólidos completamente) 9. NÃO SABE/NENHUMA RESPOSTA

N°	PERGUNTAS
41	**Durante as semanas depois que (NOME) teve diarreia quando a diarreia parou, você deu a ele/ela menos que habitual para comer, cerca da mesma quantia, ou mais que o habitual para comer?** 1. DEU A COMER MENOS 2. DEU A COMER A MESMA QUANTIDADE 3. DEU A COMER MAIS 4. NUNCA TEVE DIARREIA 9. NÃO SABE / NENHUMA RESPOSTA
42	**Já ouviu falar de SRO?** • ***SE SIM, PEÇA A MÃE PARA DESCREVER A PREPARAÇÃO DE SRO PARA TÍ.*** • ***SE NÃO, CIRCULE A RESPOSTA 4 (NUNCA OUVÍ FALAR DE SRO).*** ***[UMA VEZ A MÃE TENHA FEITO A DISCRIÇÃO, REGISTE SE ELA DESCREVEU CORRECTAMEMTEOU INCORRETAMENTE A PREPARAÇÃO DO SRO.*** ***CIRCULE 1 [CORRETAMENTE] SE A MÃE MENCIONOU O SEGUINTE:*** • USA 1 LITRO DE AGUA DE BEBER LIMPA (1 LITRO=3 GARRAFAS DE REFRESCO) • USA O PACOTE INTEIRO • DISSOLVE O PÓ COMPLETAMENTE 9. DESCREVEU CORRETAMENTE 10. DESCREVEU INCORRETAMENTE 11. OUVIU FALAR SOBRE SRO MAS MÃE RECUSA DESCREVER O PROCESSO 12. NUNCA OUVIU FALAR DE SRO

IMUNIZAÇÕES ***(Perguntas sobre imunização estão integradas a baixo.)***

VI. DOENÇAS DA INFÂNCIA

NO.	PERGUNTAS
74.	**Às vezes as crianças adoecem e precisam receber cuidado ou tratamento para doenças. Quais são os sinais de doença que indicariam que sua criança precisa de tratamento? (Qualquer outro sinal?)** ***[PERMITE-SE MULTIPLAS RESPOSTAS]*** W. NÃO SABE/NENHUMA RESPOSTA X. PARECE INDISPOSTA OU NÃO BRINCA NORMALMENTE Y. NÃO COME OU NÃO BEBE Z. LETÁRGICO OU DIFICULDADE DE DESPERTAR AA. FEBRE ALTA BB.RESPIRAÇÃO RÁPIDA OU DIFÍCIL

NO.	PERGUNTAS
	CC. VOMITA TUDO DD. CONVULÇÕES EE. OUTRO (ESPECIFIQUE)_____ FF. OUTRO (ESPECIFIQUE)_____ L. OUTRO (ESPECIFIQUE)_____

VII. PERGUNTAS ADICIONAIS DE CAPTAÇÃO RAPIDA

NO.	PERGUNTAS
75.	**Você tem alguma rede mosquiteira em sua casa?** 1. SIM 2. NÃO → **Salta para Q. #47** NÃO SABE / NENHUMA RESPOSTA → **Salta para Q. #47**
76.	**Quem dormiu ontem à noite debaixo da rede mosquiteira? (Quem mais?)** ***[PERMITE-SE RESPOSTAS MÚLTIPLAS]*** A. CRIANÇA (NOME) B. RESPONDENTE C. OUTRO INDIVIDO(S) _____ (ESPECIFIQUE)
77.	**A rede mosquiteira já foi tratada ou imergida em um líquido para repelir mosquitos ou bichos?** 1. SIM 2. NÃO 9. NÃO SABE / NENHUMA RESPOSTA

78.	**O que pode uma pessoa fazer para evitar apanhar HIV ou o vírus que causa a HIV? (Que mais?)** ***[PERMITE-SE RESPOSTAS MÚLTIPLAS]*** II. NADA JJ. ABSTER-SE DE MANTER RELACOES SEXUAIS KK. USAR PRESERVATIVOS LL. LIMITAR O SEXO A UM PARCEIRO/SER FIEL A UM UNICO PARCEIRO MM. LIMITAR O NUMERO DE PARCEIROS SEXUAIS NN. EVITAR SEXO COM PROSTITUTAS OO. EVITAR SEXO COM PESSOAS QUE TÊM MUITOS PARCEIROS PP. EVITAR RELACOES SEXUAIS COM PESSOAS DO MESMO SEXO QQ. EVITAR SEXO COM PESSOAS QUE INJETAM DROGAS INTRAVENOSAS RR. EVITAR TRANSFUSÕES DE SANGUE SS. EVITAR INJEÇÕES TT. EVITAR BEIJAR UU. EVITAR MORDIDAS DE MOSQUITO VV. PROCURAR PROTEÇÃO DE CURANDEIRO TRADICIONAL WW. EVITAR COMPARTILHAR NAVALHAS, LÂMINAS, XX. OTRO (ESPECIFIQUE) _____ YY. OUTRO (ESPECIFIQUE) _____ ZZ. NUNCA OUVIU FALAR DE HIV AAA. NÃO SABE / NENHUMA RESPOSTA

VIII. MONITORAMENTO DE CRESCIMENTO E ANTROPOMETRIA DA CRIANÇA

Nº.	PERGUNTAS
79.	**O (NOME) tem um cartão de monitoramento de crescimento?** SE SIM**: Posso vê-lo por favor?** 7. SIM, VISTO 8. NÃO DISPONÍVEL / CARTÃO PERDIDO → **salta para P. # 52** 9. NUNCA TEVE UM CARTÃO → **salta para P. # 52** 9. NÃO SABE/NENHUMA RESPOSTA → **salta para P. # 52**
80.	**OLHE PARA O CARTÃO DE MONITORAMENTO DE CRESCIMENTO DE (NOME) E VEJA SE (NOME) FOI PESADA NOS <u>PRIMEIROS DOIS MESES DE VIDA</u>** 1. SIM 2. NÃO 9. NÃO POSSO DETERMINAR COM CERTEZA

N°.	PERGUNTAS
81.	**OLHE PARA O CARTÃO DE MONITORAMENTO DE CRESCIMENTO DE (NOME) E VEJA SE (NOME) FOI PESADA NOS <u>ULTIMOS QUATRO MESES</u>** 1. SIM 2. NÃO 9. NÃO POSSO DETERMINAR COM CERTEZA
82.	**[Saltada]**

IX. **OUTRAS PERGUNTAS BASEADAS NOS Míni-KPCs**

83.	**Depois de dar à luz a (NOME) você recebeu uma dose de vitamina A (recebeu gotas na língua)?** 3. SIM 4. NÃO →salta para Q. **#54** 9. NÃO SABE / NENHUMA RESPOSTA → salta para Q. **#54**
84.	**Depois de quanto tempo após você dar a luz a (Nome) foi lhe dada a dose de vitamina A?** 5. Antes de (Nome) completar dois meses de idade 6. Depois de (Nome) completar dois meses de idade 7. A Mãe nunca recebeu Vitamina A 9. NÃO SABE / NENHUMA RESPOSTA
85.	**Quais são os sinais de perigo pós parto que indicam que a mãe deve procurar cuidados médicos?** ***[MULTIPLE ANSWERS ALLOWED]*** A. FEBRE B. EXCESSIVO SANGRAMENTO C. MAU CHEIRO NA SECREÇÃO VAGINAL D. NÃO SABE / NENHUMA RESPOSTA X. OUTRO (ESPECIFIQUE)_____
86.	**Quando amamenta (NOME) você dá ambos os seios?** 1. SIM 2. NÃO→ **Salta para Q. # 57** 9. NÃO SABE / NENHUMA RESPOSTA →**salta para Q. #57**
87.	**Quando você amamenta (NOME) normalmente esvazia completamente ambos seios?** 1. SIM 2. NÃO 9. NÃO SABE / NENHUMA RESPOSTA
88.	**Como você conserva a comida depois preparar?** 1. TAPADA OU REFREGERADA 2. NÃO MENCIONOU TAPADA OU REFREGERADA 9. NÃO SABE / NENHUMA RESPOSTA

89.	**Durante as últimas duas semanas, você recebeu visita da Mãe de Líder?** 1. SIM 2. NÃO 3. RESPONDENTE É MÃE LÍDER 9. NÃO SABE / NENHUMA RESPOSTA
90.	**Quanto tempo depois da criança nascer a mãe deveria levar para começar a amamentar?** 1. IMEDIATAMENTE/DENTRO DA PRIMEIRA HORA APÓS O PARTO 2. DEPOIS DA PRIMEIRA HORA APÓS O PARTO 9. NÃO SABE / NÃO RESPONDEU
91.	**Na sua opinião, você esta a prejudica de alguma maneira a sua criança se a amamenta durante uma nova gravidez ?** 1. SIM 2. NÃO 9. NÃO SABE/NÃO RESPONDE
92.	**Você acredita que os homens têm mais valor que as mulheres, que as mulheres têm mais valor que os homens, ou que eles são iguais?** 1. Homem vale mais 2. Mulher vale mais 3. São Iguais 9. NÃO SABE /NENHUMA RESPOSTA
93.	**Se uma mãe sabe que ela HIV+, como deveria alimentar a criança dela durante os primeiros seis meses?** 1. DAR SO LEITE MATERNO , SEM OUTOROS LIQUIDOS OU COMIDA 2. DAR LEITE MATERNO E OUTRAS COMIDAS OU LIQUIDOS 3. OUTRA RESPOSTA (INCORRECTA). QUAL? _____ 9.NÃO SABE/NENHUMA RESPOSTA
94.	**Como pode uma mulher prevenir anemia durante gravidez?** ***[SÃO PERMITIDAS MÚLTIPLAS RESPOSTAS]*** 1. Comer comidas ricas em ferro como carnes, aves, e folhas verdes 2. Comer Sal iodado 3. Tomar suplementos com ferro e acido folico) 4. Dormir de baixo da rede mosquiteira 9. NÃO SABE/NENHUMA RESPOSTA
95.	**A sua criança teve Febres nas ultimas duas semanas?** 1. Sim 2. Não → Saltar para a Pergunta #67

	9. Não Sabe/ Nenhuma Resposta → Saltar para a Pergunta #67
96.	**Você procurou aconselhamento ou tratamento quando a sua criança estava com febre?** 1. Sim 2. Não → Saltar para a Pergunta #67 9. Não Sabe/ Nenhuma Resposta → Saltar para a Pergunta #67
97.	**De quem/onde você procurou ajuda quando a sua criança teve febre na ultimas duas semanas?** *[SÃO PERMITIDAS MÚLTIPLAS RESPOSTAS]* A. Curandeiro Tradicional B. Hospital do Governo C. Unidade Sanitária D. Lideres Religiosos E. Médico/Enfermeiro Privado F. Farmácias G. Mãe Chefe treinada em AIDI -C H. Mãe Chefe não treinada em AIDI -C I. Parteira Tradicional I. Parentes ou amigos K. Não Sabe/ Nenhuma Resposta
98.	**O que provoca a Malária?** A. Picada de um mosquito B. Feitiçaria C. Uso de drogas intravenosas D. Transfusão de sangue E. Injecções F. Partilha de laminas G Tosse H. Outro (Especifique)_____ I. Não Sabe/ Nenhuma Resposta
99.	**Confira com 0 Cartão: Quantas doses da vacina DPT (NOME) tem registadas no cartão?** ____ doses de vacina de DPT registradas no seu cartão ❑ Falta cartão

	O (NOME) recebeu vacina de sarampo? ❑ Sim ❑ Não ❑ Falta cartão

X. CONTACTOS COM A SAÚDE E FONTES DE INFORMAÇÃO DE SAÚDE

N°	PERGUNTAS E FILTROS	CATEGORIAS CODIFICADAS		
100.	**Durante os últimos meses, com que freqüência você entrou em contato com cada um dos seguintes:**	FREQÜENTEMENTE (4 ou mais vezes)	ÀS VEZES (1-3 vezes)	NUNCA (0 vezes)
	Doutor?	1	2	3
	Enfermeira ou Parteira treinada?	1	2	3
	Mãe de Chefe, Educador Saúde/Trabalhador de saúde	1	2	3
	Parteira tradicional	1	2	3
	Curandeiro tradicional?	1	2	3
101.	**De onde você obtém informação geral ou aconselhamento em saúde ou nutrição?**	**Rede Formal**		
	(REGISTRE TUDO QUE FOR MENCIONADO)	Doutor		A
		Enfermeira/Parteira Treinada		B
		Mãe Chefe / Educador de Saúde/Trabalhador de saúde		C

		Parteira tradicional	D
		Rede Informal	
		Marido/Parceiro	E
		Mãe/Sogra	F
		Irmã	G
		Avô	H
		Tia	I
		Amigo/Vizinho	J
		Curandeiro tradicional	K
		Ancião de aldeia	L
		OUTRO _____ (Especifique)	X
102.	**No último mês, você recebeu alguma mensagem de saúde de quaisquer das fontes seguintes?** ***(LEIA TODAS RESPOSTAS E CIRCULE TODAS QUE FOREM SIM)*** A. Radio? B. Jornal? C. Televisão? D. Mãe de líder? E. Outro Educador de Saúde /Trabalhador de saúde?		
103.	**Posso pesar (NAME)?** ***[TAMBÉM PEÇA PESAR QUALQUER CRIANÇA NA MESMA CASA COM MENOS DE 12 MESES DE IDADE.]*** 1. SIM → **va para #73 e pese a criança** 2. NÃO → **TERMINE A ENTREVISTA**		

ANTROPOMETRIA

Registe o peso de todas crianças de 0-11 meses na casa de (NOME). Se estiverem na casa menos de três crianças de 0-11 meses de idade, vá para a casa a seguir mais próxima da entrada dianteira da casa de (NOME) e confere para ver se aquela casa tem qualquer criança de 0-11 meses de idade. Se haver crianças de 0-11m de idade lá, peca o consentimento da mãe, e pesa as crianças 0-11 meses de idade naquela casa. Continue andando à casa a seguir mais próxima da entrada dianteira da última casa visitada até um total de <u>três crianças</u> de 0-11m de idade serem pesadas. Depois faça entrevista de uma mãe/provedora de cuidados chefe de uma criança de 12-23m de idade (se ainda não fizeste isso). (A mãe/provedora de cuidados chefe da criança de 12-23m de idade NÃO deve ser a mesma mãe/provedora de cuidados chefe da criança de 0-11m de idade que você entrevistou.

73. NOME DA CRIANÇA	**GENERO**	**Data de Nascimento?** copie data de nascimento do cartão se estiver disponível. se cartão não estiver disponível registe a data de nascimento providenciada pela mãe.	**PESO** **(KG)**
(1) CRIANÇA #1: _____	❑ Masc. ❑ Fem.	_____ / _____ / _____ dd mm aaaa	_____ . ___ **kg** ❑ Confira aqui se respondente recusar pesar (NOME)
(2) CRIANÇA #2: _____	❑ Masc. ❑ Fem.	_____ / _____ / _____ dd mm aaaa	_____ . ___ **kg**
(3) CRIANÇA #3: _____	❑ Masc. ❑ Fem.	_____ / _____ / _____ dd mm aaaa	_____ . ___ **kg**

SÓ PREENCHA DADOS PARA CRIANÇA 4 SE A MÃE DE (NOME) RECUSA TER (NOME) PESADA			
(4) CRIANÇA #4: _____	❑ Masc. ❑ Fem.	_____ / _____ / _____ dd mm aaaa	_____ . ___ **kg**

FIM

Mozambique Impacto Expandido

Projeto de Sobrevivência Infantil

Conhecimento, Práticas, e Cobertura (KPC)

Questionário de Pesquisa para

Crianças 0-11 m de Idade

Revisado só para AVALIAÇÃO FINAL

30 de abril 2010

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Tom Davis, MPH

INSTRUCÕES PARA O ENTREVISTADOR

A. ESCOLHA A CASA PARA COMEÇO E PERGUNTE POR CRIANÇAS ABAIXO DE DOIS ANOS. SE VOCÊ NAO ACHAR NENHUM, ENTÃO VÁ PARA A PRÓXIMA CASA MAIS PERTO.

SE VOCÊ ENCONTRAR UMA CRIANÇA (0-11M DE IDADE), ENTÃO ENTREVISTE ESSA MÃE E VAI PARA A CASA A SEGUIR MAIS PERTO, MAIS PRÓXIMA A SEGUIR, ETC. ATÉ QUE VOCÊ ACHE UMA DE 12-23M DE IDADE. SE VOCÊ ACHAR PRIMEIRO UMA DE 12-23M DE IDADE, ENTÃO ENTREVISTE ESSA MÃE, DEPOIS VÁ PARA A PRÓXIMA CASA MAIS PERTO, A SEGUIR MAIS PRÓXIMO, ETC., ATÉ QUE VOCÊ ACHE UMA BEBE 0-11M DE IDADE.

SE VOCÊ ACHA UM BEBE E UMA DE 12-23M EM UMA CASA (E VOCÊ NÃO ENTREVISTOU NENHUMA MÃE NAQUELE LOCAL), VOCÊ ESCOLHE UM DOS DOIS AO ACASO (ALEATORIAMENTE), ENTREVISTE A MÃE DAQUELA CRIANÇA, ENTÃO VÁ PARA A PRÓXIMA CASA MAIS PERTO PARA ACHAR A CRIANÇA QUE FALTA.

SE VOCÊ ACHA UM BEBE DE 0-11M E DUAS DE 12-23M DE IDADE EM UMA CASA, POR EXEMPLO, ENTÃO ESCOLHA UM DOS TRÊS AO ACASO, DEPOIS VÁ PROCURAR A QUE FALTA NUMA CASA DIFERENTE.

UMA COISA IMPORTANTE - NÃO LEVE A MÃE DO BEBE E A MÃE DA DE 12-23M DE IDADE DA MESMA CASA. ELAS DEVERIAM SER DUAS MÃES QUE MORAM EM CASAS DIFERENTES.

B. <u>Selecção de Respondente</u>: Na primeira casa escolhida para entrevista, pergunte a um adulto na casa se há alguma criança vivendo em casa que tenha abaixo de dois anos de idade. Se existir, pergunte os seus nomes e idades. Seleccione uma dessas criaças <u>aleatoriamente</u>, e peça para falar com a mãe dessa criança. **ESCOLHA O QUESTIONÁRIO CORRETO PARA USAR BASEADO NA IDADE DA CRIANÇA.** Este questionário é para crianças de **0-11m** de idade somente. Se vai usar este questionário, verifique se a criança tem a idade que foram originalmente ditos (<u>abaixo de 24 meses</u>) e inicia o processo de consentimento abaixo. Se não encontrar nenhuma criança abaixo de dois anos na casa, prossiga para a casa a seguir mais próxima (a porta a seguir mais próxima) até que uma crança abaixo de 24 meses de idade seja achada e repita o processo acima.

C. Nós queremos entrevistar a mãe biológica se possível. Só entrevista alguém que não seja a mãe biológica da criança se a mãe biológica (1) morreu (2) esteve ausente da criança para mais de 6 meses, ou (3) deu a criança a outra pessoa cuidar regularmente (ex. porque ela não pode cuidar da criança). (Nós saltaremos as perguntas de amamentação se o principal provedor de cuidado da criança não for a mãe.) Se a mãe biológica cuida da criança regularmente, mas está a mais de 30 minutos de distancia, escolha outra criança para a entrevista.

D. A idade da criança: ao registar a idade da criança em meses **(P. #9)**, tenha a certeza de **arredonda-los para baixo**. Se esta criança tiver 2 meses e 30 dias, a criança ainda tem 2 meses. Se a criança nascesse no dia 15 de junho e hoje é 14 de agosto a criança ainda tem só **1** mes de idade.

Se a criança nascesse no dia 15 de junho e hoje é 14 de julho a criança ainda não tem um mês de idade. Por favor registe ZERO para a idade em meses. Não registre idade em semanas - i.e. Duas semanas - só em meses. Se uma criança tem menos de um mês completo de idade, registe ZERO.

CONSENTIMENTO

Antes de entrevistar uma mãe, você deve ter o consentimento dela para efectuar a entrevista. Por favor leia o consentimento informado exactamente como está escrito. Esta afirmação explica o propósito do inquérito e a natureza voluntária da participação do entrevistado. Peça a mãe a colaboração dela. Após a leitura da afirmação, você (não o respondente) deve sinalizar o espaço providenciado para afirmar que leu a afirmação para a mãe/provedora de cuidados chefe. Circule "1" se a mãe/provedora de cuidados chefe aceita ser entrevistada e prossiga aos modules. Se a mãe/provedora de cuidados chefe não aceita ser entrevistada, agradeça a ela pelo tempo, termine a entrevista, e vá para a próxima casa mais perto.

DECLARAÇÃO DE CONSENTIMENTO

Bom dia/Boa tarde. O meu nome é _____, e estou a trabalhar com a Fundação Contra Fome. Estamos a fazer uma pesquisa e gostaríamos de ter a sua participação. Eu gostaria de lhe perguntar acerca da sua saúde e a saúde de sua criança mais nova abaixo de dois anos de idade. Estas informações ajudarão (Fundação Contra Fome) a planear serviços de saúde e avaliar se está indo ao encontro de suas metas para melhorar a saúde de crianças. A pesquisa normalmente leva_____ minutos para completar. Qualquer informações que você providenciar serão mantidas estritamente confidencial e não serão mostradas a outras pessoas.

A participação nesta pesquisa é voluntária e poderá escolher não responder qualquer pergunta individual ou todas as perguntas. Porém, nós esperamos que você participará nesta pesquisa porque suas opiniões são importantes.

Quer fazer alguma pergunta acerca da pesquisa? ***[Responda qualquer pergunta que a mãe tiver.]***

Você concorda ser entrevistado?

RESPONDENTE CONCORDA SER ENTREVISTADO. . . . . 1 → **ENTREVISTE**

RESPONDENTE NÃO CONCORDA SER ENTREVISTADO …2 → **TERMINE A ENTREVISTA**

Assinatura do entrevistador: _____

Data: _____ / _____ / _____
dd mm aaaa

Questionário Número _____

Nome do Entrevistador:_____

Nome do Supervisor:_____ No AF.:_____ GC n° _____

Data da Entrevista: ____/___/____ Comunidade: _____ Distrito: _____
dd mm aaaa

Todas perguntas devem ser feitas a <u>Mães</u> ou <u>provedores de cuidado chefe</u> de crianças de menos de 12 meses de idade.

I. INFORMAÇÃO DO RESPONDENTE

ii. A mãe desta criança vive com a criança? 1. Sim 2. Não	***(FALE COM O PRINCIPAL CUIDADORA DA CRIANÇA)*** **2. Qual a sua relação com esta criança?** **(*Se for mãe - sondar* – Se é mãe biológica ou adoptiva?)** 1. Mãe Biológica 2. Mãe Adoptiva 3. Pai 4. Avó 5. Tia 6. Outro (Especifique:)_____
3. *(Pergunte a respondente)* Que idade tem? _____ anos 9. NÃO SABE/NENHUMA RESPOSTA	**4. GÊNERO DO RESPONDENTE:** ❑ Feminino ❑ Masculino

N°.	PERGUNTAS

39.	**Quantas crianças das que moram na sua casa são menores de cinco anos de idade?** 12. UMA CRIANÇA 13. DUAS CRIANÇAS 14. TRÊS OU MAIS CRIANÇAS 9. NÃO SABE/NENHUMA RESPOSTA
40.	**Quantas dessas crianças são suas crianças biológicas?** 10. UMA CRIANÇA 11. DUAS CRIANÇAS 12. TRÊS OU MAIS CRIANÇAS 9. NÃO SABE/NENHUMA RESPOSTA
41.	**Quais são os nomes, sexo e data de nascimento das tuas duas crianças mais novas?**

	NOME	**SEXO**	**DATA DE NASCIMENTO**
1		1. MASC. 2. FEM.	__ __ / __ __ / _____ dd mm aaaa
2		1. MASC. 2. FEM.	__ __ / __ __ / _____ dd mm aaaa

TODAS PERGUNTAS SUBSEQÜENTES PERTENCEM À CRIANÇA SELECIONADA COM MENOS DE UM ANO DE IDADE. DEVE SE USAR O " (NOME)"

*ENTREVISTADOR: Explique que você gostaria **depois** de verificar a informação no "cartão de saúde" da criança (cartão de imunização de cartão monitora de crescimento) e peça **para ver** se ela os tiver. O cartão de clínica da criança também pode ter a data de nascimento.*

N.°	QUESTIONS
42.	**Qual é a data de nascimento de (NOME) ?** ***[CONFIRME COM O CARTÃO DE SAÚDE]*** ____ / ____ / _____ ❑ Cartão não disponível 9. NÃO SABE/NENHUMA RESPOSTA dia mes ano
43.	**Que idade tem (NOME)?** _____ meses ❑ NÃO SABE/NENHUMA RESPOSTA ***[NOTA - Se a criança for 12-23m de idade, USE OUTRO QUESTIONÁRIO!]***
9.a	**Sexo da criança?** 3. MASCULINO

	4. FEMININO 9. NÃO SABE/NENHUMA RESPOSTA
44.	**Durante quantos anos você frequentou a escola?** _____ anos ***[SE NUNCA REGISTE '00'; SE NÃO SABE, REGISTE '99']***
45.	**Quem cuida de (NOME) quando você está fora de casa?** **(Se ninguém mais, marque "4" abaixo. Se alguém mais para além da mãe, Pergunte:)** **Essa pessoa ouviu os ensinos da Mãe chefe em grupo ou durante uma visita domiciliaria no último mês?** **19.** SIM, ESSA PESSOA OUVIU O ENSINO DA MÃE DE CHEFE NO MÊS PASSADO **20.** NÃO, ESSA PESSOA NÃO OUVIU O ENSINO DA MÃE CHEFE NO MÊS PASSADO **21.** NÃO SABE/NENHUMA RESPOSTA **22.** NENHUMA OUTRA PESSOA CUIDA DA CRIANÇA **23.** MÃE CHEFE NÃO FEZ VISITA DOMICILIARIA OU ENSINO EM GRUPO NO ÚLTIMO MÊS.

II. AGUA E SANEAMENTO

NO.	PERGUNTAS
46.	**Agora eu gostaria de lhe fazer algumas perguntas acerca da sua casa. Qual é a principal fonte de água de beber para os membros de sua casa?** 1. CANALIZADA ATÉ A RESIDENCIA / QUINTAL / TERRENO 2. TORNEIRA PUBLICA 3. POÇO ABERTO NA RESIDÊNCIA / QUINTAL / TERRENO 4. POÇO PÚBLICO 5. POÇO PROTEGIDO NA RESIDÊNCIA / QUINTAL / TERRENO 6. POÇO PUBLICO PROTEGIDO 7. FONTENÁRIA / RIO / AFLUENTE 8. LAGOA / LAGO / BARRAGEM 9. AGUA DA CHUVA 10. OUTRO (ESPECIFIQUE)_____ 99. NÃO SABE / NENHUMA RESPOSTA

47. **Na semana passada, você fez qualquer coisa à agua dada a (NOME) para torná-la segura para beber? Se fez, o quê? (O que mais?)** ***[PERMITE-SE RESPOSTAS MULTIPLAS]***

A. NÃO FEZ NADA / NÃO TRATOU A ÁGUA
B. FERVEU A ÁGUA
C. ADICIONOU JAVEL / CLORO NA AGUA
D. USOU UM PRODUTO COMERCIAL PARA PURIFICAÇÃO DE AGUA (ex., CERTEZA)
E. FILTROU ATRAVÉS DUM PANO LIMPO
F. USOU UM FILTRO DE AGUA (cerâmica, areia, composto)
G. USOU DESINFECÇÃO SOLAR (deixou no sol)
H. USOU SEDIMENTAÇÃO (deixou assim e sedimento caiu/desceu ao fundo)
X. OUTRO (Por favor especifique:) _____

48. **A última vez que (NOME) fez necessidades maiores, onde foi que ele/ela defecou?**

1. USOU UMA LATRINA, CASA DE BANHO OU NUMA COVA ESPECIALMENTE CAVADA NO CHÃO
2. USOU PINICO (PINICO DE DENTRO DE CASA)
3. USOU FRALDAS LAVAVEIS
4. USOU FRALDAS DESCARTÁVEIS
5. FEZ NO CHÃO DENTRO DA CASA
6. FOI PARA FOR A DA CASA NO CHÃO (MAS NÃO NUMA COVA FEITA)
7. FEZ NA ROUPA
8. OUTRO (ESPECIFIQUE): _____
9. NÃO SABE/ NENHUMA RESPSTA

49. **A sua casa tem um lugar especial para lavar mãos?**

7. SIM
8. NÃO→**salta para P. # 17**
9. NÃO SABE / NENHUMA RESPSTA→**salta para P. # 17**

50. ***PEÇA PARA VER O LUGAR USADO MAIS FREQUENTEMENTE PARA LAVAGEM DAS MÃOS E OBSERVA SE OS SEGUINTES ITENS ESTÃO PRESENTES:***

	SIM	NÃO
(A) AGUA/TORNEIRA	1	2
(B) SABÃO, CINZA OU OUTRO DETERGENTE DE LAVAGEM	1	2
(C) BACIA	1	2

51.	**Quando você lava suas mãos com sabão/cinza? (Quando mais?)** ***[PERMITE-SE RESPOSTAS MULTIPLAS]*** S. NÃO SABE/NENHUMA RESPOSTA T. NUNCA U. ANTES DE PRERARAÇÃO DA COMIDA V. ANTES DE DAR DE COMER AS CRIANÇAS W. DEPOIS DE DEFECAR X. DEPOIS DE CUIDAR DE UMA CRIANÇA QUE DEFECOU X. OUTRO (ESPECIFIQUE)_____

III: CUIDADOS MATERNO INFANTIL

N°	PERQUNTAS
	[SE RESPONDENTE NÃO É A MÃE BIOLÓGICA DE (NOME), SALTA PARA PERGUNTA #30]
52.	**Antes de você dar à luz a (NOME) recebeu uma injecção no braço para prevenir o bebé de apanhar tétano, ou seja, convulsões depois de nascimento?** 7. SIM 8. NÃO→**salta para P. # 19 b.** NÃO SABE/NENHUMA RESPOSTA→**salta para P. # 19 b.**
53.	**Quantas vezes você recebeu tal injecção?** 1. UMA VEZ 2. DUAS VEZES 3. MAIS QUE DUAS VEZES 9. NÃO SABE /NENHUMA RESPOSTA
19 b.	**Quando você deu à luz a (NOME), você recebeu em sua casa visita da Mãe chefe ou de um trabalhador de saúde durante a PRIMEIRA SEMANA depois do parto?** 3. SIM 4. NÃO 9. NÃO SABE /NENHUMA RESPOSTA

54.	**Agora gostaria de lhe perguntar acerca do tempo em que deu a luz à (NOME). Quem a assistiu durante o parto de (NOME)? (Quem mais?)** ***[PERMITE-SE RESPOSTAS MÚLTIPLAS]*** AA. NÃO SABE/NÃO SE LEMBRA/NENHUMA RESPOSTA BB.MÉDICO

	CC. ENFERMEIRA/PARTEIRA DD. ASSISTENTE DE PARTEIRA EE. PARTEIRA TRADICIONAL FF. TRABALHADOR DE SAÚDE DA COMUNIDADE GG. MEMBRO DA FAMÍLIA _____ (ESPECIFIQUE RELACIONAMENTO COM RESPONDENTE) HH. NINGUÉM II. MÃE CHEFE X. OUTRO (ESPECIFIQUE:) _____
55.	**Quando você estava grávida de (NOME), durante quantos dias tomou suplementos férreos (sal ferroso)?** ***[MOSTRE COMPRIMIDOS]*** ***[SE O RESPONDENTE MENCIONAR MESES, CONVERTA PARA DIAS MULTIPLICANDO POR 30.]*** _____ dias 99. Não sabe / Nenhuma resposta
56.	**Quando você estava gravida de (Nome) quantas consultas pré-natal fez?** ____ meses ❑ Não sabe / Nenhuma resposta

IV: AMAMENTAÇÃO E NUTRIÇÃO INFANTIL/CRIANÇA

N°	PERGUNTAS
	[SE O RESPONDENTE NÃO É MÃE BIOLOGICA DE (NOME), SALTE PARA PERGUNTA #30]
57.	**Você já alguma vez amamentou (NOME)?** 5. SIM 6. NÃO→ **Salte para P. #30** 9. NÃO SABE/NENHUMA RESPOSTA→**salta para P. #30**
58.	**Depois de quanto tempo após o nascimento (Nome) você pôs no peito para mamar?** 7. IMEDIATAMENTE/DENTRO DA PRIMEIRA HORA APÓS O PARTO 8. ENTRE 1 E 8 HORAS 9. DEPOIS DAS PRIMEIRAS OITO HORAS 11. NÃO SABE/NENHUMA RESPOSTA
59.	**Durante os primeiros três dias após o parto, você deu a (NOME) o liquido que saia dos seus seios?** 5. SIM 6. NÃO 9. NÃO SABE/NENHUMA RESPOSTA
60.	**Durante os primeiros três dias após o parto, você deu a (NOME) qualquer outra coisa para comer ou beber antes de alimentá-lo/a com leite materno?** 5. SIM 6. NÃO → **Salte para P. #** 28 9. NÃO SABE/NENHUMA RESPOSTA

N°	PERGUNTAS
61.	**Durante os primeiros três dias após o parto, o que você deu a (NOME) para comer ou beber?** ***[NÃO LEIA A LISTA. MARCA TUDO O QUE A MÃE MENCIONA. INCITE COM " qualquer outra coisa "? DEPOIS DE CADA RESPOSTA]*** ***[PERMITE-SE RESPOSTAS MULTIPLAS]*** Q. NÃO SABE/NENHUMA RESPOSTA R. LEITE (PARA ALÉM DE AMAMENTAÇÃO) S. SOMENTE AGUA T. AGUA COM AÇÚCAR E/OU SAL U. SUMO DE FRUTA V. CHÁ/ INFUSÕES W. MEDICAMENTOS TRADICIONAIS LIQUIDOS OU SEMI-LIQUIDOS X. FÓRMULA INFANTIL XII. OUTRO (ESPECIFICA)_____
62.	**Você está actualmente amamentando a (NOME)?** **7.** SIM (salte para #30) 8. NÃO 9. NÃO SABE/NENHUMA RESPOSTA
63.	**Por quanto tempo você amamentou (Nome)?** ***[SE MENOS DE UM MÊS, REGISTE "00" MESES]*** ___ ____ MESES 9. NÃO SABE/NENHUMA RESPOSTA

N°	PERGUNTAS
64.	**Agora gostaria de lhe perguntar acerca dos tipos de líquidos que (NOME) bebeu ontem durante o dia e à noite. Será que (NOME) bebeu qualquer dos seguintes líquidos ontem durante o dia e à noite?** ***[LEIA A LISTA DE LÍQUIDOS (B ATÉ H, COMEÇANDO COM "LEITE MATERNO"). CIRCULE A LETRA SE A CRIANÇA BEBEU O LÍQUIDO EM QUESTÃO -- PERMITE-SE MULTIPLA RESPOSTA.*** A. Leite materno? B. Agua? C. Formula infantil comercialmente produzida? D. Qualquer outro leite além de leite materno como leite em pó, ou leite fresco de origem animal? E. Sumo de Fruta ? F. Chá ou café? G. Medicamentos tradicionais líquidos ou semi- líquidos? H. Maheu I. Qualquer outro líquido? **(ESPECIFIQUE:)** _____ J. RESPONDENTE NÃO MENCIONA LÍQUIDO / NENHUMA RESPOSTA DADA

N°	QUESTIONS
65.	**Gostaria de lhe perguntar acerca da comida que (NOME) comeu ontem durante o dia e à noite, quer separadamente ou associada com outras comidas. Será que (NOME) comeu quaisquer das comidas seguintes ontem durante o dia ou à noite? Qualquer outra coisa?** ***[LEIA ESTA LISTA DE COMIDAS. CIRCULE A LETRA SE A CRIANÇA COMEU A COMIDA EM QUESTÃO --PERMITE-SE RESPOSTAS MÚLTIPLAS]*** **FFF.** Sopa de aveia? **GGG.** Qualquer [NOME DE MARCA DE COMIDA DE BEBÊ COMERCIALMENTE FORTALECIDA, ex. Cerelac] **HHH.** Pão, arroz, macarrão, bolachas, biscoitos, ou qualquer outra comida feita de grãos? **III.** Batata branca, inhames brancos, mandioca, ou qualquer outra comida feita de raízes? **JJJ.** Abóbora, cenoura, batata doce de polpa alaranjada? **KKK.** Legume verde escuro? **LLL.** Manga madura ou papaia? **MMM.** Outra fruta ou vegetais? **NNN.** Fígado, rim, coração, ou outro órgãos de origem animal? **OOO.** Carne de boi, carne de porco, cordeiro, cabra, coelho (ou insere carne de caça) **PPP.** Galinha, pato, ou outras aves? **QQQ.** Ovos? **RRR.** Peixe fresco ou seco ou mariscos? **SSS.** Comida feita de feijões, ervilhas, ou lentilhas? **TTT.** Nozes? **UUU.** Queijo ou iogurte? **VVV.** Comida feita com outro tipo de óleo, gordura ou manteiga? **WWW.** Qualquer outra comida sólida ou semi - sólida? **XXX.** RESPONDENTE NÃO MENCIONOU NENHUMA COMIDA / NENHUMA RESPOSTA DADA
66.	**Será que (NOME) bebeu qualquer coisa de um beberom ontem ou na noite passada?** 1. SIM 2. NÃO 9. NÃO SABE/NENHUMA RESPOSTA

67.	**Quantas vezes (NOME) comeu comidas sólidas, semi - sólidas, ou macias diferente de líquidos ontem durante o dia e à noite? (Que tipo de comida comeu ele/ela?)** ***NOTA!:*** • ***NÓS QUEREMOS DESCOBRIR QUANTAS VEZES A CRIANÇA COMEU O SUFICIENTE PARA ESTAR SACIADA.*** • ***LANCHES PEQUENOS E ALIMENTOS PEQUENOS COMO UMA OU DUAS MORDIDAS NA COMIDA DA MÃE OU IRMÃ <u>NÃO</u> DEVERIAM SER CONTADAS.*** • ***LÍQUIDOS NÃO CONTAM PARA ESTA PERGUNTA.*** • ***<u>NÃO</u> INCLUA SOPAS MAGRAS OU CALDO, SOPAS DE AVEIA AGUADAS, OU QUALQUER OUTRO LÍQUIDO.*** **[USE PERGUNTAS QUE SONDA PARA AJUDAR O RESPONDENTE A SE LEMBRA TODAS AS VEZES QUE A CRIANÇA COMEU ONTEM]** __ ___ NUMERO DE VEZES QUE A CRIANÇA COMEU 99. NÃO SABE/NENHUMA RESPOSTA
68.	**Quando você fez comida para (NOME) ontem, adicionou óleo à comida dele?** 10. SIM 11. NÃO 12. NÃO FEZ COMIDA PARA CRIANÇA ONTEM 9. NÃO SABE/NENHUMA RESPOSTA

69.	**A (NOME) recebeu uma dose de vitamina A como esta durante os últimos 6 meses?** ***[MOSTRE AMPOLA/CAPSULA/XAROPE]*** 7. SIM 8. NÃO 9. NÃO SABE / NENHUMA RESPOSTA

V. DIARREA

N°	PERGUNTAS
70.	**A (NOME) teve diarreia nas últimas 2 semanas**? 11. SIM 2. NÃO →**Salta para P. # 42** 9. NÃO SABE/NENHUMA RESPOSTA

N°	PERGUNTAS
71.	**O que foi dado para tratar a diarréia ou prevenir desidratação? (Qualquer outra coisa?)** ***[PERMITE-SE RESPOSTAS MÚLTIPLAS]*** BB. NÃO SABE/NENHUMA RESPOSTA CC. NADA DD. COMPRIMIDOS OU XAROPE (DIFERENTE DE ZINCO) EE. INJEÇÕES FF. LÍQUIDOS (INTRAVENOSOS) GG. REMEDIOS CASEIROS/MEDICAMENTOS A BASE DE ERVAS (dados em pequenas quantidades) HH. SRO EM PACOTE II. LIQUIDOS CASEIROS RECOMENDADOS – AGUA, SUMO, ETC. JJ. TABLETES DE ZINCO X. OUTRO (ESPECIFIQUE)_____
72.	**Quando (NOME) teve diarreia, você amamentou a ela/ele menos que o habitual, a mesma quantidade, ou mais que o habitual?** 1. AMAMENTOU MENOS 12. AMAMENTOU A MESMA QUANTIDADE 13. AMAMENTOU MAIS 14. CRIANÇA NÃO MAMOU 9. NÃO SABE/NENHUMA RESPOSTA
39	**Quando (NOME) teve diarreia, deu a ele/ela beber menos que o habitual, a mesma quantidade ou mais que o habitual ?** **24.** DEU A BEBER MENOS **25.** DEU A BEBER A MESMA QUANTIDADE **26.** DEU A BEBER MAIS **27.** NÃO DEU <u>NADA</u> PARA BEBER (ex., parou de dar líquidos completamente) 9. NÃO SABE/NENHUMA RESPOSTA
40	**Quando (NOME) teve diarreia, deu a ele/ela a comer menos que o habitual, a mesma quantidade, ou mais que o habitual ?** 1. DEU A COMER MENOS 2. DEU A COMER A MESMA QUANTIDADE 3. DEU A COMER MAIS 4. NÃO DEU <u>NENHUMA COISA</u> PARA COMER (ex., parou de dar alimentos sólidos completamente) 9. NÃO SABE/NENHUMA RESPOSTA

N°	PERGUNTAS
41	**Durante as semanas depois que (NOME) teve diarreia quando a diarreia parou, você deu a ele/ela menos que habitual para comer, cerca da mesma quantia, ou mais que o habitual para comer?** 1. DEU A COMER MENOS 2. DEU A COMER A MESMA QUANTIDADE 3. DEU A COMER MAIS 4. NUNCA TEVE DIARREIA 9. NÃO SABE / NENHUMA RESPOSTA
42	**Já ouviu falar de SRO?** • ***SE <u>SIM</u>, PEÇA A MÃE PARA DESCREVER A PREPARAÇÃO DE SRO PARA TÍ.*** • ***SE <u>NÃO</u>, CIRCULE A RESPOSTA 4 (NUNCA OUVÍ FALAR DE SRO).*** ***[UMA VEZ A MÃE TENHA FEITO A DISCRIÇÃO, REGISTE SE ELA DESCREVEU CORRECTAMEMTEOU INCORRETAMENTE A PREPARAÇÃO DO SRO.*** ***CIRCULE 1 [CORRETAMENTE] SE A MÃE MENCIONOU O SEGUINTE:*** • USA <u>1 LITRO</u> DE AGUA DE BEBER LIMPA (1 LITRO=3 GARRAFAS DE REFRESCO) • USA O PACOTE <u>INTEIRO</u> • <u>DISSOLVE</u> O PÓ COMPLETAMENTE 13. DESCREVEU CORRETAMENTE 14. DESCREVEU INCORRETAMENTE 15. OUVIU FALAR SOBRE SRO MAS MÃE RECUSA DESCREVER O PROCESSO 16. NUNCA OUVIU FALAR DE SRO

IMUNIZAÇÕES ***(Perguntas sobre imunização estão integradas a baixo.)***

VI. DOENÇAS DA INFÂNCIA

NO.	PERGUNTAS
104.	**Às vezes as crianças adoecem e precisam receber cuidado ou tratamento para doenças. Quais são os sinais de doença que indicariam que sua criança precisa de tratamento? (Qualquer outro sinal?)** ***[PERMITE-SE MULTIPLAS RESPOSTAS]*** GG. NÃO SABE/NENHUMA RESPOSTA HH. PARECE INDISPOSTA OU NÃO BRINCA NORMALMENTE II. NÃO COME OU NÃO BEBE JJ. LETÁRGICO OU DIFICULDADE DE DESPERTAR KK. FEBRE ALTA LL. RESPIRAÇÃO RÁPIDA OU DIFÍCIL

NO.	PERGUNTAS
	MM. VOMITA TUDO NN. CONVULÇÕES OO. OUTRO (ESPECIFIQUE)_____ PP. OUTRO (ESPECIFIQUE)_____ L. OUTRO (ESPECIFIQUE)_____

VII. PERGUNTAS ADICIONAIS DE CAPTAÇÃO RAPIDA

NO.	PERGUNTAS
105.	**Você tem alguma rede mosquiteira em sua casa?** 1. SIM 2. NÃO → **Salta para Q. #47** NÃO SABE / NENHUMA RESPOSTA → **Salta para Q. #47**
106.	**Quem dormiu ontem à noite debaixo da rede mosquiteira? (Quem mais?)** ***[PERMITE-SE RESPOSTAS MÚLTIPLAS]*** A. CRIANÇA (NOME) B. RESPONDENTE C. OUTRO INDIVIDO(S) _____ (ESPECIFIQUE)
107.	**A rede mosquiteira já foi tratada ou imergida em um líquido para repelir mosquitos ou bichos?** 1. SIM 2. NÃO 9. NÃO SABE / NENHUMA RESPOSTA

108.	**O que pode uma pessoa fazer para evitar apanhar HIV ou o vírus que causa a HIV? (Que mais?)** ***[PERMITE-SE RESPOSTAS MÚLTIPLAS]*** BBB. NADA CCC. ABSTER-SE DE MANTER RELACOES SEXUAIS DDD. USAR PRESERVATIVOS EEE. LIMITAR O SEXO A UM PARCEIRO/SER FIEL A UM UNICO PARCEIRO FFF. LIMITAR O NUMERO DE PARCEIROS SEXUAIS GGG. EVITAR SEXO COM PROSTITUTAS HHH. EVITAR SEXO COM PESSOAS QUE TÊM MUITOS PARCEIROS III. EVITAR RELACOES SEXUAIS COM PESSOAS DO MESMO SEXO JJJ. EVITAR SEXO COM PESSOAS QUE INJETAM DROGAS INTRAVENOSAS KKK. EVITAR TRANSFUSÕES DE SANGUE LLL. EVITAR INJEÇÕES MMM. EVITAR BEIJAR NNN. EVITAR MORDIDAS DE MOSQUITO OOO. PROCURAR PROTEÇÃO DE CURANDEIRO TRADICIONAL PPP. EVITAR COMPARTILHAR NAVALHAS, LÂMINAS, QQQ. OTRO (ESPECIFIQUE) _____ RRR. OUTRO (ESPECIFIQUE) _____ SSS. NUNCA OUVIU FALAR DE HIV TTT. NÃO SABE / NENHUMA RESPOSTA

VIII. MONITORAMENTO DE CRESCIMENTO E ANTROPOMETRIA DA CRIANÇA

Nº.	PERGUNTAS
109.	**O (NOME) tem um cartão de monitoramento de crescimento?** SE SIM**: Posso vê-lo por favor?** 10. SIM, VISTO 11. NÃO DISPONÍVEL / CARTÃO PERDIDO → **salta para P. # 52** 12. NUNCA TEVE UM CARTÃO → **salta para P. # 52** 9. NÃO SABE/NENHUMA RESPOSTA → **salta para P. # 52**
110.	**OLHE PARA O CARTÃO DE MONITORAMENTO DE CRESCIMENTO DE (NOME) E VEJA SE (NOME) FOI PESADA NOS <u>PRIMEIROS DOIS MESES DE VIDA</u>** 1. SIM 2. NÃO 9. NÃO POSSO DETERMINAR COM CERTEZA

N°.	PERGUNTAS
111.	**OLHE PARA O CARTÃO DE MONITORAMENTO DE CRESCIMENTO DE (NOME) E VEJA SE (NOME) FOI PESADA NOS <u>ULTIMOS QUATRO MESES</u>** 1. SIM 2. NÃO 9. NÃO POSSO DETERMINAR COM CERTEZA
112.	**[Saltada]**

IX. **OUTRAS PERGUNTAS BASEADAS NOS Míni-KPCs**

113.	**Depois de dar à luz a (NOME) você recebeu uma dose de vitamina A (recebeu gotas na língua)?** 5. SIM 6. NÃO →salta para Q. **#54** 9. NÃO SABE / NENHUMA RESPOSTA → salta para Q. **#54**
114.	**Depois de quanto tempo após você dar a luz a (Nome) foi lhe dada a dose de vitamina A?** 8. Antes de (Nome) completar dois meses de idade 9. Depois de (Nome) completar dois meses de idade 10.A Mãe nunca recebeu Vitamina A 9. NÃO SABE / NENHUMA RESPOSTA
115.	**Quais são os sinais de perigo pós parto que indicam que a mãe deve procurar cuidados médicos?** ***[MULTIPLE ANSWERS ALLOWED]*** A. FEBRE B. EXCESSIVO SANGRAMENTO C. MAU CHEIRO NA SECREÇÃO VAGINAL D. NÃO SABE / NENHUMA RESPOSTA X. OUTRO (ESPECIFIQUE)_____
116.	**Quando amamenta (NOME) você dá ambos os seios?** 1. SIM 2. NÃO→ **Salta para Q. # 57** 9. NÃO SABE / NENHUMA RESPOSTA →**salta para Q. #57**
117.	**Quando você amamenta (NOME) normalmente esvazia completamente ambos seios?** 1. SIM 2. NÃO 9. NÃO SABE / NENHUMA RESPOSTA
118.	**Como você conserva a comida depois preparar?** 1. TAPADA OU REFREGERADA 2. NÃO MENCIONOU TAPADA OU REFREGERADA 9. NÃO SABE / NENHUMA RESPOSTA

119.	**Durante as últimas duas semanas, você recebeu visita da Mãe de Líder?** 1. SIM 2. NÃO 3. RESPONDENTE É MÃE LÍDER 9. NÃO SABE / NENHUMA RESPOSTA
120.	**Quanto tempo depois da criança nascer a mãe deveria levar para começar a amamentar?** 1. IMEDIATAMENTE/DENTRO DA PRIMEIRA HORA APÓS O PARTO 2. DEPOIS DA PRIMEIRA HORA APÓS O PARTO 9. NÃO SABE / NÃO RESPONDEU
121.	**Na sua opinião, você esta a prejudica de alguma maneira a sua criança se a amamenta durante uma nova gravidez ?** 1. SIM 2. NÃO 9. NÃO SABE/NÃO RESPONDE
122.	**Você acredita que os homens têm mais valor que as mulheres, que as mulheres têm mais valor que os homens, ou que eles são iguais?** 1. Homem vale mais 2. Mulher vale mais 3. São Iguais 9. NÃO SABE /NENHUMA RESPOSTA
123.	**Se uma mãe sabe que ela HIV+, como deveria alimentar a criança dela durante os primeiros seis meses?** 1. DAR SO LEITE MATERNO , SEM OUTOROS LIQUIDOS OU COMIDA 2. DAR LEITE MATERNO E OUTRAS COMIDAS OU LIQUIDOS 3. OUTRA RESPOSTA (INCORRECTA). QUAL? _____ 9.NÃO SABE/NENHUMA RESPOSTA
124.	**Como pode uma mulher prevenir anemia durante gravidez?** ***[SÃO PERMITIDAS MÚLTIPLAS RESPOSTAS]*** 1. Comer comidas ricas em ferro como carnes, aves, e folhas verdes 2. Comer Sal iodado 3. Tomar suplementos com ferro e acido folico) 4. Dormir de baixo da rede mosquiteira 9. NÃO SABE/NENHUMA RESPOSTA
125.	**A sua criança teve Febres nas ultimas duas semanas?** 1. Sim 2. Não → Saltar para a Pergunta #67

	9. Não Sabe/ Nenhuma Resposta → Saltar para a Pergunta #67
126.	**Você procurou aconselhamento ou tratamento quando a sua criança estava com febre?** 1. Sim 2. Não → Saltar para a Pergunta #67 9. Não Sabe/ Nenhuma Resposta → Saltar para a Pergunta #67
127.	**De quem/onde você procurou ajuda quando a sua criança teve febre na ultimas duas semanas?** *[SÃO PERMITIDAS MÚLTIPLAS RESPOSTAS]* A. Curandeiro Tradicional B. Hospital do Governo C. Unidade Sanitária D. Lideres Religiosos E. Médico/Enfermeiro Privado F. Farmácias G. Mãe Chefe treinada em AIDI -C H. Mãe Chefe não treinada em AIDI -C I. Parteira Tradicional I. Parentes ou amigos K. Não Sabe/ Nenhuma Resposta
128.	**O que provoca a Malária?** A. Picada de um mosquito B. Feitiçaria C. Uso de drogas intravenosas D. Transfusão de sangue E. Injecções F. Partilha de laminas G Tosse H. Outro (Especifique)_____ I. Não Sabe/ Nenhuma Resposta
129.	**Confira com 0 Cartão: Quantas doses da vacina DPT (NOME) tem registadas no cartão?** ____ doses de vacina de DPT registradas no seu cartão ❑ Falta cartão

	O (NOME) recebeu vacina de sarampo? ❑ Sim ❑ Não ❑ Falta cartão

X. CONTACTOS COM A SAÚDE E FONTES DE INFORMAÇÃO DE SAÚDE

N°	PERGUNTAS E FILTROS	CATEGORIAS CODIFICADAS		
130.	**Durante os últimos meses, com que freqüência você entrou em contato com cada um dos seguintes:**	FREQÜENTEMENTE (4 ou mais vezes)	ÀS VEZES (1-3 vezes)	NUNCA (0 vezes)
	Doutor?	1	2	3
	Enfermeira ou Parteira treinada?	1	2	3
	Mãe de Chefe, Educador Saúde/Trabalhador de saúde	1	2	3
	Parteira tradicional	1	2	3
	Curandeiro tradicional?	1	2	3
131.	**De onde você obtém informação geral ou aconselhamento em saúde ou nutrição?**	**Rede Formal**		
	(REGISTRE TUDO QUE FOR MENCIONADO)	Doutor		A
		Enfermeira/Parteira Treinada		B
		Mãe Chefe / Educador de Saúde/Trabalhador de saúde		C
		Parteira tradicional		D
		Rede Informal		
		Marido/Parceiro		E
		Mãe/Sogra		F
		Irmã		G
		Avô		H
		Tia		I

		Amigo/Vizinho	J
		Curandeiro tradicional	K
		Ancião de aldeia	L
		OUTRO _____ (Especifique)	X
132.	**No último mês, você recebeu alguma mensagem de saúde de quaisquer das fontes seguintes?** ***(LEIA TODAS RESPOSTAS E CIRCULE TODAS QUE FOREM SIM)*** A. Radio? B. Jornal? C. Televisão? D. Mãe de líder? E. Outro Educador de Saúde /Trabalhador de saúde?		
133.	**Posso pesar (NAME)?** ***[TAMBÉM PEÇA PESAR QUALQUER CRIANÇA NA MESMA CASA COM MENOS DE 12 MESES DE IDADE.]*** 1. SIM → **va para #73 e pese a criança** 2. NÃO → **TERMINE A ENTREVISTA**		

ANTROPOMETRIA

Registe o peso de todas crianças de 0-11 meses na casa de (NOME). Se estiverem na casa menos de três crianças de 0-11 meses de idade, vá para a casa a seguir mais próxima da entrada dianteira da casa de (NOME) e confere para ver se aquela casa tem qualquer criança de 0-11 meses de idade. Se haver crianças de 0-11m de idade lá, peca o consentimento da mãe, e pesa as crianças 0-11 meses de idade naquela casa. Continue andando à casa a seguir mais próxima da entrada dianteira da última casa visitada até um total de <u>três crianças</u> de 0-11m de idade serem pesadas. Depois faça entrevista de uma mãe/provedora de cuidados chefe de uma criança de 12-23m de idade (se ainda não fizeste isso). (A mãe/provedora de cuidados chefe da criança de 12-23m de idade NÃO deve ser a mesma mãe/provedora de cuidados chefe da criança de 0-11m de idade que você entrevistou.

73. NOME DA CRIANÇA	**GENERO**	**Data de Nascimento?** copie data de nascimento do cartão se estiver disponível. se cartão não estiver disponível registe a data de nascimento providenciada pela mãe.	**PESO** **(KG)**
(1) CRIANÇA #1: _____	❑ Masc. ❑ Fem.	_____ / _____ / _____ dd mm aaaa	_____ . ___ **kg** ❑ Confira aqui se respondente recusar pesar (NOME)
(2) CRIANÇA #2: _____	❑ Masc. ❑ Fem.	_____ / _____ / _____ dd mm aaaa	_____ . ___ **kg**
(3) CRIANÇA #3: _____	❑ Masc. ❑ Fem.	_____ / _____ / _____ dd mm aaaa	_____ . ___ **kg**

SÓ PREENCHA DADOS PARA CRIANÇA 4 SE A MÃE DE (NOME) RECUSA TER (NOME) PESADA			
(4) CRIANÇA #4: _____	❑ Masc. ❑ Fem.	_____ / _____ / _____ dd mm aaaa	_____ . ___ **kg**

FIM